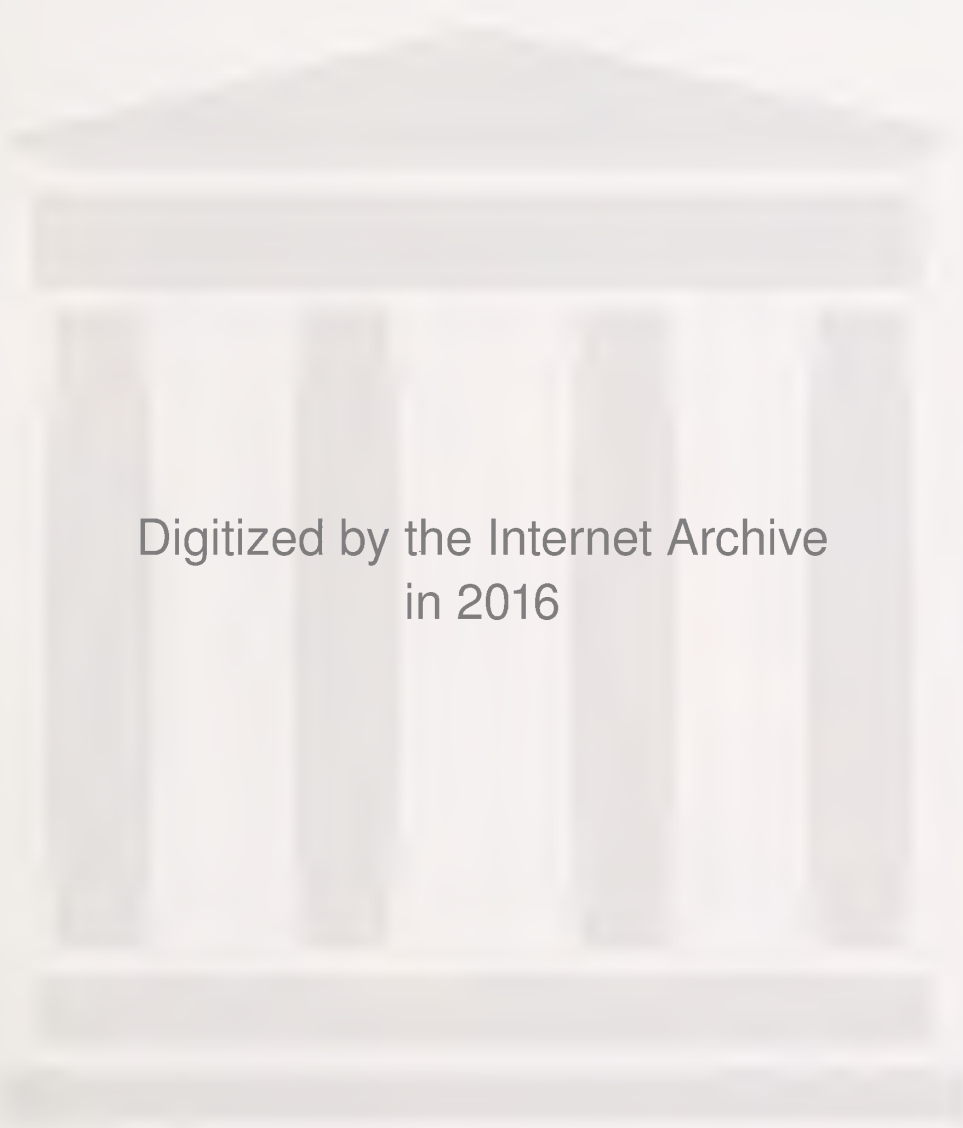


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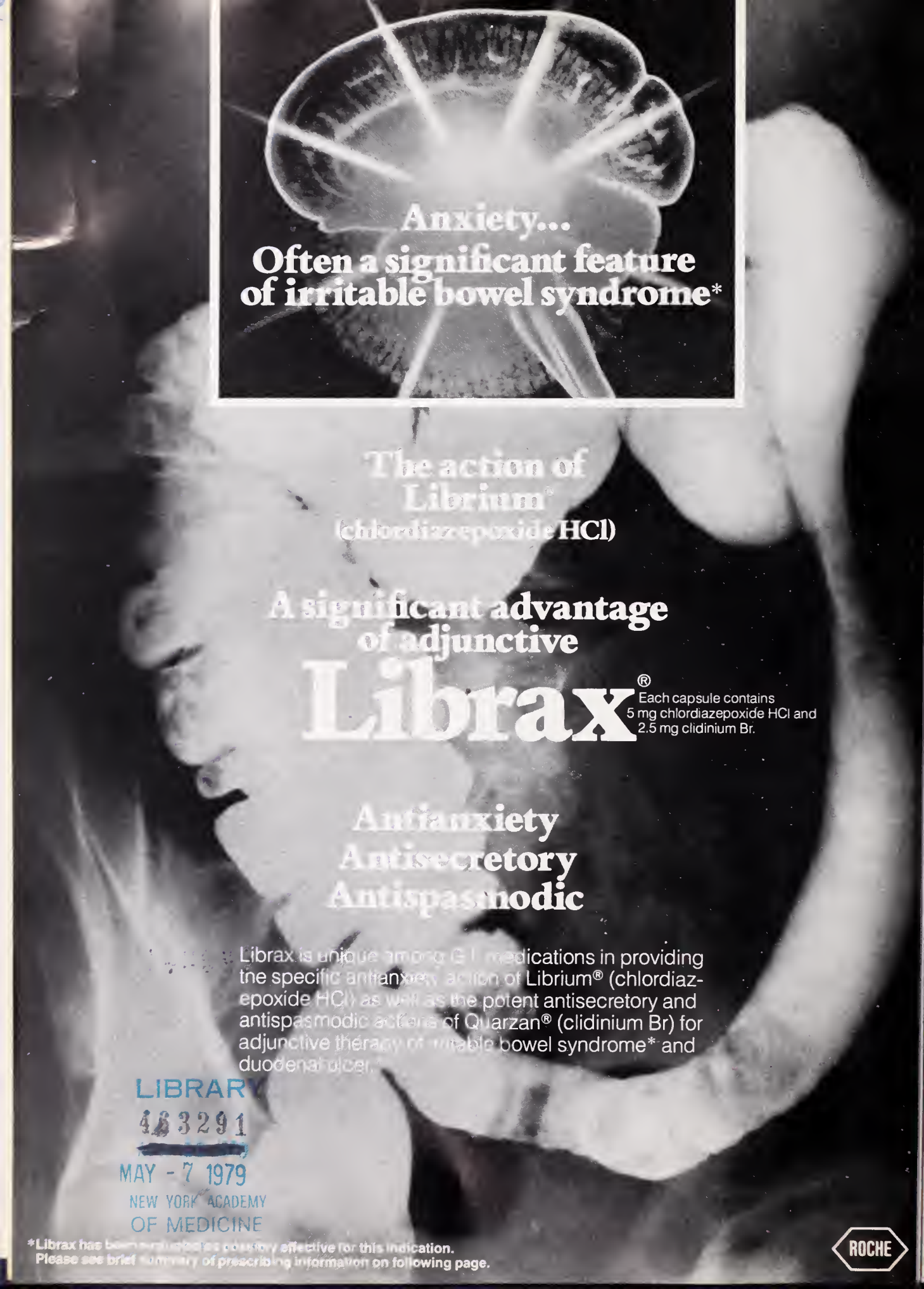
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Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

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Preoperative Irradiation in Operable Cancer of the Rectum: Report of the Toronto Trial — W. D. Rider et al (The Princess Margaret Hosp, Toronto, Ontario, Canada) *Can J Surg* 20:335-340 (July) 1977.

The authors studied the value of preoperative radiotherapy in 125 patients with cancer of the rectum. The patients were divided into two groups: control (no irradiation) and experimental (irradiation), according to Dukes' pathological staging. The crude survival indicated no difference between the two groups, but analysis by stage and group demonstrated that for patients with a Dukes' stage C lesion, 500 rads of cobalt-60 gamma irradiation a few hours before excision of the lesion approximately doubled the probability of survival at five years. The prospect of surgical cure is three times higher in cancers arising above the peritoneal reflection than in those arising below it. If the practice of abdominoperineal resection is to continue, the authors recommend that preoperative irradiation become a routine procedure.

The Value of Breast Screening in Women Less Than Fifty Years of Age — A. H. Letton et al (Suite 500 Professional Bldg East, 315 Boulevard NE, Atlanta, GA 30312) *Cancer* 40:1-3 (July) 1977.

In the four years that the Breast Cancer Detection Demonstration Project has been receiving patients, 5,810 women under the age of 50 years were examined. Screening of asymptomatic women by xeromammography is definitely of advantage in this group whose greatest cause of death is cancer of the breast: 71.8% of their cancers were found by xeromammography. Of these, 43.8% had in situ cancer and only 12.5% of those cancers found had axillary spread. This group should have a five-year cure rate of 87.1% rather than 63% as is the experience of unscreened women. The absorbed rads averaged 0.4632 to each breast per year. At the end of five years this would cause an estimated increase in risk from 7% to 7.162%. To increase survival rate by 24.1% against a theoretical increased risk of 0.16% is definitely worthwhile.

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Is Infusion Phlebitis Preventable? — I. H. Frazer et al (4 Sciennes House Place, Edinburgh, Scotland) *Br Med J* 2:232 (July 23) 1977.

Infusion-associated phlebitis was recorded in a general surgical unit. Phlebitis developed in 53 of 93 cannulated veins. The incidence rose from 4.3% at 24 hours to 100% after five days. Polypropylene canulae were associated with a significantly shorter mean duration of infusion before phlebitis than fluoroethylenepropylene canulae.

Delineation of Lesions of the Base of the Skull by Computed Tomography — H. Nakagawa and B. S. Wolf (Mt. Sinai Hosp, New York, NY 10029) *Radiology* 124:75-80 (July) 1977.

It is possible to delineate the extent of tumors related to the base of the skull by computed tomography in two planes. With current scanners, thin sections are possible and the artifacts produced by the bone are minimal. Bone and soft-tissue details can be visualized with clinically useful resolution. Precise evaluation of the extent of such lesions is important in determining surgical or radiotherapeutic approaches. Six illustrative cases are presented.

Liver Neoplasms and the Oral Contraceptives — W. S. Keifer, Jr. (1145 Broadway, Seattle, WA 98122) and J. C. Scott, *Am J Obstet Gynecol* 128:448-454 (June 15) 1977.

For sixteen years (1954 to 1970) millions of women used oral steroids for contraception. In this time span the authors could not find any cases of liver neoplasms in women using oral contraceptives. However, since 1970, there have been 138 cases reported in the English literature. Nine additional cases including an unusual case report, are described. Evidence for the oral contraceptive as an agent in causing liver neoplasms is circumstantial but nevertheless substantial. At present, the etiology of liver neoplasms is an enigma. Close clinical surveillance with an awareness of this potentially fatal pathologic entity is essential in women who have ingested oral contraceptives.

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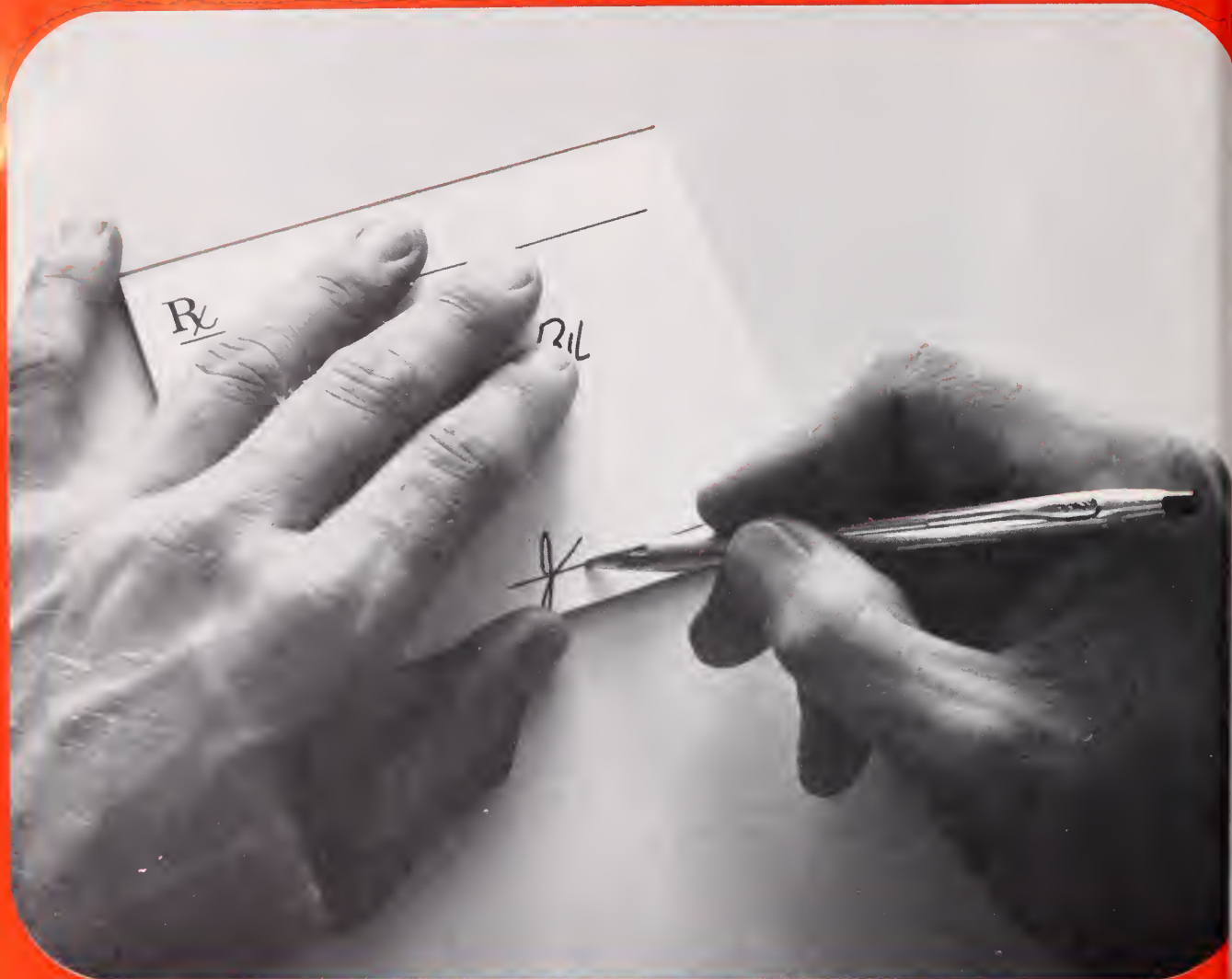
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Use in Pregnancy: Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults.

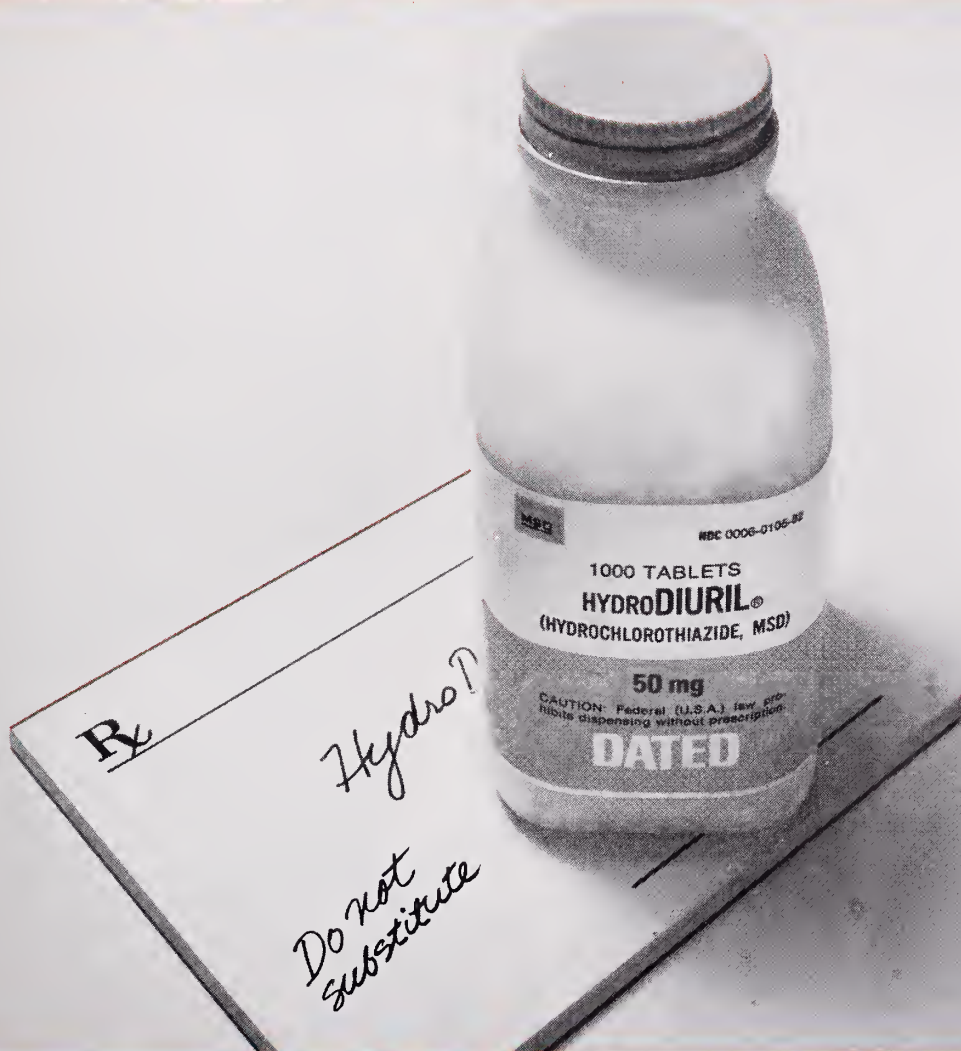
Nursing Mothers: Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.

Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting ex-

cessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting. Hypokalemia may develop, especially with brisk diuresis in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, with inadequate oral electrolyte intake. Hypokalemia can sensitize or exaggerate response of heart to toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged, latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal im-

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ment becomes evident, consider withholding or discontinuing
etic therapy. Thiazides may decrease serum PBI levels without
s of thyroid disturbance. Calcium excretion is decreased by
zides. Pathologic changes in the parathyroid gland with hyper-
emia and hypophosphatemia have been observed in a few patients
rolonged therapy, thiazides should be discontinued before testing
parathyroid function.

verse Reactions: *Gastrointestinal System*—Anorexia; gastric ir-
ion; nausea; vomiting; cramping; diarrhea; constipation; jaundice
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Central Nervous System—Dizziness; vertigo; paresthesias; headache;
hopsia.

Hematologic—Leukopenia, agranulocytosis; thrombocytopenia;
stic anemia.

Cardiovascular—Orthostatic hypotension (may be aggravated by
hol, barbiturates, or narcotics).

Sensitivity—Purpura; photosensitivity; rash; urticaria; necrotizing
itis (vasculitis) (cutaneous vasculitis); fever; respiratory distress
ding pneumonitis; anaphylactic reactions

er—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm;
kness; restlessness; transient blurred vision.
enever adverse reactions are moderate or severe, thiazide dosage
uld be reduced or therapy withdrawn.

e: When used with other antihypertensive drugs, careful observa-
s for changes in blood pressure must be made, especially during
al therapy. Dosage of other antihypertensive agents must be

reduced by at least 50 percent as soon as this drug is added to the
regimen. As blood pressure falls under the potentiating effect of this
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antihypertensive drugs may be necessary.

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Television Epilepsy and Pattern Sensitivity

— S. B. Stefansson et al (Runwell Hosp, Wickford, Essex, England) *Br Med J* 2:88-89 (July 9) 1977.

Of 32 photosensitive patients referred for routine clinical EEG examination, 23 showed induction of paroxysmal EEG activity by viewing linear patterns. Twelve of the pattern-sensitive patients were sensitive only when the patterns vibrated, but ten were sensitive to both static and vibrating patterns. The incidence of sensitivity to static pattern is more than five times greater than that in other series and suggests that visual pattern in the environment may play a more important role in seizure induction than has hitherto been thought. Twenty-seven patients, including all the pattern-sensitive cases, were sensitive to domestic television.

Blood Pressure in Children and Adolescents

— C. Cassimos et al (Pediatric Clinic of Thessaloniki Univ, Thessaloniki, Greece) *Acta Paediatr Scand* 66:439-443 (July) 1977.

Blood pressure (BP) levels were recorded in 2,223 male and 2,205 female children and adolescents ranging in age from 7 to 18 years. In addition, 521 male adults (soldiers) ranging in age from 21 to 25 years were included in the study. Children and adolescents who participated in the survey were selected at random from the elementary and high schools. The results of the study showed that a gradual increase occurred in the systolic, as well as in the diastolic component of blood pressure from 7 to 18 years of age. By contrast, there was no increase with age in the systolic and diastolic blood pressure in the young male adult subjects, whose BP measurements were comparable to those observed in children. A child was characterized as hypertensive according to the criteria outline by Master et al. Children with BP between the 90th and the 95th percentile were considered as suspect hypertensive; those with BP exceeding the 95th percentile were considered definitely hypertensive. The overall incidence of hypertension in children in this survey was 3.1%.

Tablets Percocet®-5

DESCRIPTION Each tablet of PERCOCET®-5 contains 5mg oxycodone hydrochloride (WARNING: May be habit forming), 325mg acetaminophen (APAP).

INDICATIONS For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS Hypersensitivity to oxycodone or acetaminophen.

WARNINGS Drug Dependence Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of PERCOCET®-5, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, PERCOCET®-5 is subject to the Federal Controlled Substances Act.

Usage in ambulatory patients Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using PERCOCET®-5 should be cautioned accordingly.

Interaction with other central nervous system depressants Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with PERCOCET®-5 may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Usage in pregnancy Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, PERCOCET®-5 should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Usage in children PERCOCET®-5 should not be administered to children.

PRECAUTIONS Head injury and increased intracranial pressure The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions The administration of PERCOCET®-5 or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special risk patients PERCOCET®-5 should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

ADVERSE REACTIONS The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include euphoria, dysphoria, constipation, skin rash and pruritus.

DOSAGE AND ADMINISTRATION Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. PERCOCET®-5 is given orally. The usual adult dose is one tablet every 6 hours as needed for pain.

DRUG INTERACTIONS The CNS depressant effects of PERCOCET®-5 may be additive with that of other CNS depressants. See WARNINGS.

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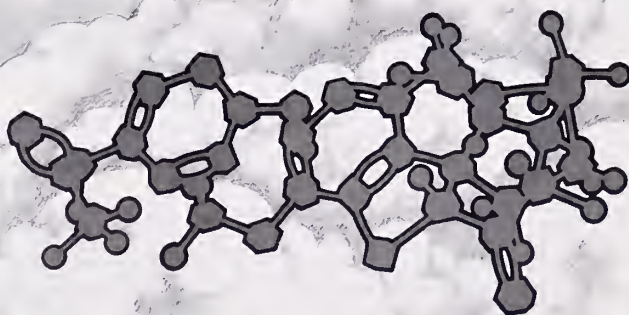


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Percocet®-5

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**When aspirin is
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Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea and vomiting. The frequency of adverse reactions is related to the serum theophylline level and are not usually a problem of serum theophylline levels below 20 µg/ml.

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X-Ray Exposure and Premature Aging — R. Bertell (Roswell Park Memorial Institute, Buffalo, NY 14263) *J Surg Oncol* 9:379-392 (No. 4) 1977.

A hypothesis of an aging effect of exposure to ionizing radiation in humans is proposed and given precise mathematical expression. The assumption is made that the biological changes that occur when humans are exposed to ionizing radiation from medical x-ray are comparable to those occurring through the natural aging process, since both factors are known to increase the relative risk of nonlymphatic leukemia. This assumption focuses on this one aspect of aging only. The hypothesis that aging and exposure to ionizing radiation are comparable for increasing the relative risk of nonlymphatic leukemia is tested against the data from the Tri-State Leukemia Survey. This explains the data in a statistically acceptable way, giving an estimate of one rad skin dose exposure to the trunk as comparable to one year natural aging.

The Role of Transbronchial Lung Biopsy in Diffuse Pulmonary Disease — C. W. Smith et al (G. F. Murray, Div of Cardiothoracic Surgery, Univ of North Carolina School of Medicine, Chapel Hill, NC 27514) *Ann Thorac Surg* 24:54-58 (July) 1977.

Forty consecutive patients underwent flexible fiberoptic transbronchial lung biopsy for diagnosis of diffuse nodular or infiltrative lung disease. Biplane fluoroscopic examination with image intensification greatly facilitated accurate placement of the biopsy forceps near the pleura. Specimens of lung parenchyma were obtained for culture and histological study in every case. A pathological diagnosis was correctly established in 34 of 40 patients. Transbronchial biopsy was helpful in the clinical management of an additional four patients. Biopsy results were not accurate in two patients. No significant morbidity was associated with the procedure. Fiberoptic transbronchial lung biopsy is a safe and useful adjunct to the diagnosis of parenchymal lung disease.

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York
Lincoln
Omaha
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Omaha
Lexington

AD-HOC LIAISON COMMITTEE WITH STATE GOVERNMENTAL AGENCIES

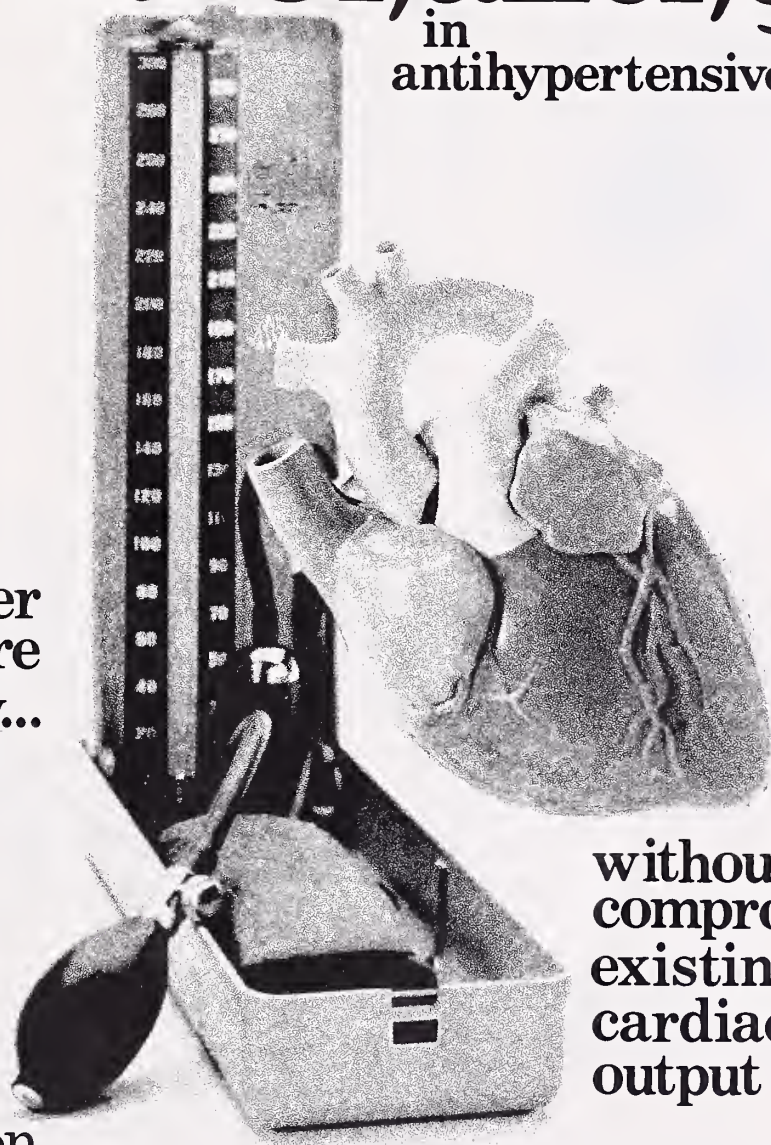
Warren G. Bosley, M.D., Chm.
James R. Adwers, M.D.
Charles M. Bressman, M.D.
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A Dual Challenge

in
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to lower
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existing
cardiac
output

in hypertension

TABLETS: 250 mg, 500 mg, and 125 mg

ALDOMET[®] (METHYLDOPA | MSD)

helps lower blood pressure effectively...
usually with no direct effect on
cardiac function—cardiac output
is usually maintained

ALDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if previous methyl dopa therapy has been associated with liver disorders. It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyl dopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

For a brief summary of prescribing information, please see following page.

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in hypertension

ALDOMET[®]

(METHYLDOPA/MSD)

helps lower
blood pressure
effectively...
usually with no
direct effect on
cardiac function—
cardiac output is
usually maintained

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive,

problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, occasionally with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients. Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Pregnancy and Nursing: Use of any drug in women who are or may become pregnant or intend to nurse requires that anticipated benefits be weighed against possible risks; possibility of fetal injury or injury to a nursing infant cannot be excluded. Methyldopa crosses the placental barrier, appears in cord blood, and appears in breast milk.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of urinary uric acid by the phosphotungstate method, serum creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular

disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has occurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia. Positive tests for antinuclear antibody, LE cells, and rheumatoid factor.

Allergic: Drug-related fever, lupus-like syndrome, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third months of therapy; increased dosage or adding a diuretic frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 500.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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MSD MERCK SHARP & DOHME

THE NEBRASKA MEDICAL JOURNAL

WHAT IT FEELS LIKE TO DIE

The strange feeling of tranquility and peace, and the sensation of floating that have been described by death-watchers have nothing to do with dying, and it is time we said so. Critically ill patients who have described these experiences have not been near death at all. When you are really near to death, you die, and the sensations you experience just before dying may be entirely different from what you feel when you are simply ill. And when you feel whatever you feel *immediately* before you die, you do not come back and talk about it, because you are dead.

Looking at the patient's face will not tell you what thoughts are going on inside of him, if there are any. He may seem to be smiling, if you want to think he is smiling, when he may really be unconscious, or when he may actually be in pain.

No matter how sick these patients seem to be, and however diligently you pursue these reportings, you will never get there; and you will never know what it feels like to die.

The only way to find out what it feels like to die, is to die.

—F.C.

ARE YOU DOING A
TONSIL TRANSPLANT?

Television and theater movies begin with screen credits so nearly endless as to extend in time and on screen almost to the end of the story. And nearly halfway through the plot, when you have despaired of learning the name of the production you are watching, its title is shown to you for a fleeting instant.

I like the idea. It may look as though the one in charge was not sure of his plot, and as if he wanted all the credit there was before time ran out, but I like it.

I make the incision, and the nurses and spectators look at me, wondering what the operation is going to be. But I tell them the anesthesiologist's name instead, and then

mine, and after a while, my assistant's. They ask again, wordlessly, perhaps. But I go on with the action, exploring the open belly.

Now I know what I will do. I will tell them the name of the operation I am going to do when I know it myself.

Operating Room Five will be Channel Five. Come to OR 5 at eleven o'clock. The name of the action is: *To Be Announced*. It may start off looking like a gallbladder and turn into an appendix.

I don't think it's different from what we do now. Laparotomy means they're operating on your front, and laminectomy on your back, and that's about how we schedule surgery today.

We'll let you know. We'll tell you before it's too late, when we find out, that is. Tune in same time tomorrow.

—F.C.

STUDENT RESEARCH DAY

Student Research Day was held at the University of Nebraska Medical Center on November 11, 1977, and I attended as an Honorary Chairman. 32 research projects were described, and I listened to as many as I could, and I found them more than interesting, with a combination of skill, industry, and the use of sophisticated apparatus made available to the students.

At midday, I listened with great interest to Dr. Ritter who spoke on "Research without bounds." It has become the custom to invite someone of national repute to address the research workers, the faculty, and honorary chairmen; and the list of guest speakers is impressive.

The invitation extended to me was kind, and I enjoyed listening to the speakers. Opportunities and apparatus like this were not available to students when I was in school, and encouraging the curious mind and the willing researcher is admirable. This is my third Student Research Day visit, and if I am asked, I will come again, and again.

—F.C.

THE EDITOR AND THE AUTHOR

I do not comment editorially in connection with articles that appear in the same issue of the *Journal*. It is like instant replay, which requires you to watch two football games while only one is going on. Do it if you like; I see no point in telling you on one page what the author has said on another.

Besides, the work and the conclusions are the author's, not the editor's.

—F.C.

WHAT DO DOCTORS DIE OF?

Doctors die of what nondoctors die of. We all die of infection, neoplasm, degeneration

with its heart disease and stroke, and injury. I once counted suicides in doctors and concluded that these were three times as great as among nonphysicians.

We probably die younger than our patients. We work longer hours, we are up at night, we enter the sick room where others do not go, we commonly neglect ourselves on the theories that we know what to do and that we can get help when we need it, and we are victims of a high rate of suicide.

But I wonder if our death certificates indicate more infection and less cancer than in nonphysicians, or perhaps more degeneration and less trauma. It's not terribly important, but it's something to think about.

—F.C.

1976 Nebraska Maternal Mortality Review

for Maternal Child Health Committee Nebraska Medical Association

A review of maternal deaths for Nebraska in 1976 reveals seven deaths occurring in women who were pregnant or who had delivered within the preceding three months. One of the seven deaths, a non-obstetric death, was due to a carcinoma of the stomach, with widespread metastasis. Of the remaining six deaths, four were direct obstetric deaths, and two were apparently indirect obstetric deaths.

One indirect obstetric death occurred some five weeks after an uneventful term delivery, under conduction anesthesia. About one month later, the patient was examined, hospitalized, dismissed and readmitted with severe headaches. In spite of numerous tests and consultations, the patient died a week later. The autopsy showed bilateral subdural hematomas, without apparent cause. The second indirect obstetric death occurred approximately four weeks after delivery, and a post-partum tubal ligation. The patient was DOA on arrival at an ER. Autopsy revealed massive pulmonary embolism. The birth certificate indicated intrapartum sepsis at the time of delivery.

The other four deaths were direct obstetric deaths. Three of these were patients delivered by Cesarean section. One patient died with a pelvic abscess and post operative sepsis. One patient died of uncontrollable hemorrhage, and the third was an apparent anesthetic death. The fourth patient died after vaginal delivery, with an apparent abruption of the placenta and associated amniotic fluid embolus or unrecognized hemorrhage.

The four direct obstetric deaths for 1976 represent some improvement over the six direct obstetric deaths that were reported for 1975. In spite of this apparent improvement, the maternal mortality rate is not significantly better. There seems little doubt

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Chairman
Maternal Child Health Committee
Nebraska Medical Association

that we need continuing review and discussion of maternal deaths.

Nationally, the future of maternal mortality committees is debatable. It is argued that such committees and their reviews have had little impact on the numbers of maternal deaths. A few states have even dropped their maternal mortality committees. Conversely, there is a newly organized group, "The Midwest Conference of Maternal Mortality Study Committees," who propose combining the maternal mortality reports from several states to accrue more meaningful statistics. Nebraska has been invited to participate in this organization.

Nebraska is somewhat at the crossroads as far as maternal mortality review. Over the past fifteen years, the Nebraska Medical Association has supported the principle of maternal mortality review, but strictly on a voluntary basis, and only by questionnaire. The other states in our area review their mortalities after personal interviews with the attending physician. In spite of excellent cooperation by Nebraska physicians, the information obtained on our questionnaires is often sketchy or incomplete. At times, prolonged delays occur between the maternal death and the completion of the questionnaire, or the questionnaire is never completed.

Decisions may be forthcoming as to which direction Nebraska's maternal mortality study will take. In the opinion of the MCH Committee, the review process should be improved and expanded to include review of the patient's record and personal interview with the attending physician. It has been

suggested that the future impact of the MCH Committee might be aimed at perinatal morbidity and mortality. Such suggestions are most worthwhile and deserve consideration, but it would seem desirable to have one functioning review committee before expanding to other areas.

A list of the maternal deaths for 1976 follows.

MATERNAL MORTALITY REVIEW 1976

76-1

A 22 year old, Para I, Gravida II, who died in the second month of pregnancy, of widespread carcinoma of stomach, with metastasis.

NON-OBSTETRIC

76-2

A 23 year old, Para 0, Gravida II, who died three hours after the Cesarean Section delivery of a living 7 lb. infant. Death was attributed to shock, due to a "bleeding diathesis, secondary to osteogenesis imperfecta." The patient had a life time history of osteogenesis imperfecta and was advised against pregnancy. No autopsy.

DIRECT OBSTETRIC

76-3

A 30 year old, Para III, Gravida IV, who died some five minutes after the low forceps delivery of a 6 lb. 2 oz. infant under local anesthesia. The baby was quite depressed, requiring resuscitation. The patient was unattended for a short time, and upon return, was unresponsive, with dilated pupils and no blood pressure, pulse or respirations. No response to resuscitative efforts. No autopsy.

DIRECT OBSTETRIC

76-4

A 21 year old, Para V, Gravida VI, AB I, who died five weeks after the uneventful term delivery of a 6 lb. 4 oz. male infant, using continuous spinal anesthesia. The pa-

tient complained of some occipital headaches, post partum, but was dismissed on her third post partum day. One month later she was seen in clinics, admitted to hospital, discharged and readmitted with severe headaches. She was examined by neurology, medicine and anesthesia services. At the final admission, one week later, she showed nystagmus and increased drowsiness. Skull x-rays were negative. Abruptly became unresponsive, with no recovery. Autopsy showed bilateral subdural hematoma, cause undetermined.

INDIRECT OBSTETRIC

76-5

A 28 year old, Para 0, Gravida I, who died during the Cesarean Section delivery of an 8 lb. 15 oz. infant under spinal anesthesia. The patient had been in labor some 28 hours without significant progress. A spinal was given and surgery started but the patient experienced respiratory arrest and she had no response to resuscitative measures. Autopsy failed to show a cause for death.

DIRECT OBSTETRIC

76-6

A 28 year old, Indian, who was delivered by Cesarean section and died from massive GI hemorrhage from a stress ulcer, associated with sepsis, endometritis, parametritis and abdominal abscess. No autopsy. (Questionnaire not returned).

DIRECT OBSTETRIC

76-7

A 32 year old, primagravida, delivered a 5 lb. 6 oz. infant with question of EDC, but evidence of fetal distress. One day following delivery she had a post partum tubal ligation. Temperature elevation on second post operative day, treated with Ampicillin for three days; dismissed on fourth day. Seen three weeks post partum, without complications. DOA on arrival at ER, three and one half weeks after delivery, Autopsy showed massive pulmonary embolism.

INDIRECT OBSTETRIC

Fifty Years of Medicine

IT all began in the year 1910. My father, an ordained Methodist minister, after our usual evening family prayer, asked, "Son, what are you going to be when you grow up?" Without hesitation, the answer was, "A doctor."

The year 1910 was important for other reasons: (1) Halley's comet made its appearance and was predicted to return every 75 years but to us Hoosiers Halley's comet meant the coming of the end of the world and (2) 1910 was the migration of my family to the state of Nebraska and the climate was ideal for the cure of tuberculosis. Mother's doctor stated she has pulmonary tuberculosis but it seems that Nebraska's pure air cured her for she lived a long and active life, dying at the age of 81.

My family arrived at the small village of Elsie, Nebraska and lived for a while in a sod house. Mother gave birth to my only brother. A Doctor Bell was called who lived 20 miles away in Grant, Nebraska. He drove by horse and buggy and arrived after my brother's birth. Due to mother's previous experience of 5 children and with the help of neighbors, mother and all was well. Doctor Bell impressed me so that I came to realize the scarcity of Doctors. I am sure this also was a factor in my desire of being a Doctor.

After my first job of herding cattle, working in a shoe and grocery store, laying brick for a new building at Madrid, Ne.; working with thrashing crews, I came home to Maywood, Nebraska and asked mother to pack my suitcase as I was leaving for University Place to attend Nebraska Wesleyan University. She stated my father was there attending a Methodist Church Conference. I found my father and through the influence of the Chancellor, I was presented to an elderly widow and to live there for taking care of the home. While at Nebraska Wesleyan, working my way through college, I met my sweetheart of high school days at Maywood, Nebraska, Helen Chamberlain, and we were married.

ESLEY J. KIRK, M.D.
Omaha, Nebraska

At Nebraska Wesleyan University I took a premedical course and graduated with an A.B. degree. I was accepted by the University of Nebraska Medical College and graduated in 1926. And later, after my M.D. degree was given, an M.A. degree in Biochemistry. After getting a substitute for my internship in Denver, I took a house officership at the Douglas County Hospital of Omaha. This was advisable as I needed the salary to take my family to Boston, Mass. where I was appointed to a residency in medicine at the Peter Bent Brigham Hospital and also granted a Fellowship in Research at Harvard Medical College. Later, I was appointed Junior Associate Physician at the Peter Bent Brigham Hospital and Harvard Medical College.

After three years, I returned to the University of Nebraska Medical College and was appointed as Instructor in Medicine; later an Associate Professor of Internal Medicine and finally at the age of 65 was given an honorary degree of Emeritus Professor of Internal Medicine. I also was appointed as Physician in Charge of the Medical Department of Armour and Company as an Internist. I was accepted in the American Board of Internal Medicine. In 1940 I was made a Fellow of the American College of Physicians and an Honorary member of the Alpha Omega Alpha Honorary Medical Society. Later, I became a Charter Member of the Mid-West Medical Society, past President of the Nebraska Methodist Hospital Staff in 1952 and Past President of the Optimist Civic Club of Omaha. Of all the publications that I had, the one I'm most proud was the "Studies of Edema" including my thesis for my M.A. degree from the Biochemical Department of the University College of Medicine.

Medicine is sick today. The present illness is well known and being described the country over. What is the etiology? Is it internal factors or outside factors, or both? First, have any of us failed in our motives of

love and service to mankind or is medicine being attacked from without? If from without can it be possible that we are developing a government of inflexible ideals: a government of bureaucracy and forgetting the voice of the people?

Treatment of Advanced Mammary Cancer — A Multi-modality Approach

ADVANCED carcinoma of the breast presents a major problem to the general and oncologic surgeon. The estimates for 1976 predict 88,700 new cases of breast cancer in the U.S. with 33,100 deaths.¹ The physician treating advanced breast carcinoma is faced with a myriad of treatment protocols which only adds to his dilemma.

Disseminated breast cancer when approached from a multi-disciplinary view need not be hopeless. Major centers are reporting favorable responses in the majority of cases. Classically, treatment has been directed towards a sequential modality approach from ablative surgery to various additive regimens. When the disease progressed, cytotoxic agents were added, usually single, with multiple drug therapy reserved for advanced disease.

The object of this paper will be to explore the various modalities of treatment available. An approach to disseminated breast cancer will then be formulated as a guide for the physician dealing with this disease not practicing in a major oncologic center.

Hormonal Treatment of Advanced Breast Carcinoma

Hormonal treatment has been the bulwark of therapy in advanced cases. The report of Huggins and Bergenstal² in 1951 demonstrated the effectiveness of adrenalectomy in metastatic mammary carcinoma. Consistent results following ablative surgery in postmenopausal women have been reported. Adrenalectomy and oophorectomy performed simultaneously or sequentially in premenopausal women have yielded similar results.

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Department of Surgery
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Creighton University
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Omaha, Nebraska

Remissions following adrenalectomy are reported as objective if there is a greater than 25% reduction in size of all measurable lesions for a duration of six months. Subjective improvement is defined as symptomatic improvement with no advancement in metastatic disease over this same period. Responses of less than six months are considered as treatment failures. Results following castration, or with additive therapy may be reported utilizing a three month criteria.

A review of the literature reveals a uniform response rate to major ablative surgery. Dao and Nemoto from Roswell Park reported a response rate of 34% for adrenalectomy;³ Fracchia and associates from Memorial Hospital reporting on 500 cases demonstrated a 32% response;⁴ Horsley noted a 35% response;⁵ and Moore and associates from Boston a 40% response rate.⁶

At the City of Hope National Medical Center, we have been interested in this treatment approach. In 1962, we first published our results with 248 adrenalectomies done for metastatic breast cancer with an objective remission rate of 38%. Our series

has been updated and reported several times since our initial communication. In 1975, we reported on 680 cases of bilateral adrenalectomy with an overall response rate of 36%.⁸ In our series 50% of patients surviving five years following bilateral adrenalectomy were free of disease.

In reviewing the literature and our adrenalectomy experience, several important concepts emerge. Most important is an objective response of no more than 40 percent. Patients with extensive hepatic involvement (over 25%), cerebral metastasis, pulmonary lymphangitic spread, hypercalcemia, and a short disease-free interval have uniformly poor results, while patients presenting with an inflammatory carcinoma of the breast have benefited from this form of treatment.

Castration in premenopausal women has been reported to be effective without concomitant adrenalectomy in one third of patients. However, in a randomized sequential series at our institution, only 17% of patients undergoing oophorectomy had an objective response.⁹ Additive hormonal treatment utilizing estrogens, androgens or progestins^{10,12} has given responses from 20 to 40 per cent. This correlates with the 20% objective and 31% overall response noted with additive hormonal therapy at our institution.⁹

Experience with sequential therapy utilizing oophorectomy in premenopausal women and additive hormonal therapy in postmenopausal women was initial treatment prior to adrenalectomy has yielded several interesting conclusions. These are supported by others interested in ablative surgery.^{6,11} Patients initially responding to oophorectomy have an increased chance to respond to sequential adrenalectomy when their disease progresses. Patients failing to respond to oophorectomy may, however, also respond to adrenalectomy. In the series reported by Yonemoto and Tan⁹ there was a 43% overall response in castration failures. These reports are encouraging; however, further examination of the literature reveals another salient point and that is premenopausal women failing to respond to castration rapidly become poor candidates for adrenalectomy due to progression of their disease. In our series, only one-third of the 80% failing to

obtain a remission with castration were able to undergo a subsequent adrenalectomy.

Based on this evidence, early bilateral oophorectomy in combination with adrenalectomy may represent the best approach to endocrine management, even in the premenopausal women. This course of treatment will yield the highest overall response rate though it does select against the patient that would benefit from sequential management. This criticism must be viewed in light of the more effective chemotherapy available to the surgical oncologist at this time. Additive hormonal therapy is effective in approximately one-third of postmenopausal patients and should be used as the initial treatment in patients not thought to be surgical candidates.

Endocrine therapy yields at best a 40% response in the absence of selection on the basis of hormonal dependency. Case selection thus becomes critical in order that patients not undergo hormonal manipulation needlessly. The clinical importance of estrogen receptors and the L-dopa test in determining hormonal dependency has been well demonstrated.^{13,16}

In a review of 436 collected cases, it was noted that 55-60% of patients with positive estrogen receptors responded favorably to hormonal management while response was seen in less than five per cent without appreciable estrogen receptors.¹³ Ongoing studies examining the presence of progesterone and other hormone receptors appears to offer a higher degree of predictability though these determinations remain investigational at this time.

Sasaki and associates have recently reported a comparison of estrogen receptor determinations and the L-dopa test.¹⁶ L-dopa is known to suppress serum levels of prolactin. Prolactin is necessary for tumor growth in experimental systems. Patients with painful bony metastasis given L-dopa may experience a transient subjective decrease in their bone pain. Their study demonstrated an excellent correlation between the L-dopa test and estrogen receptor determinations. This test, though subjective, offers the clinician an aid in determining the hormonal dependency of metastatic breast

tumors when no accessible lesion is available for biopsy. The use of anti-estrogen compounds may yield similar results.

Our initial conclusion regarding the early use of oophorectomy and adrenalectomy must be modified to take into account hormonal dependency. Estrogen receptor determinations are currently available at most major centers, and are also commercially available. Patients with advanced disease would benefit from an estrogen receptor determination as an aid in determining the potential response to endocrine therapy. However, this is not feasible in all instances and utilization of the L-dopa test may yield helpful information in those cases. L-dopa, however, though commercially available, has not been approved by the FDA for breast cancer, and its use should be relegated to institutions actively investigating it at this time. The determination of estrogen receptors may be performed during the management of the primary breast lesion and thus be available in the advent of recurrent disease. It has been demonstrated that the majority of patients do not vary in their estrogen receptor assay during the course of their disease^{14,15} though sequential determinations may be helpful as patients losing their positive receptors may have a poorer prognosis.

Therefore, patients with positive estrogen receptors and/or a positive L-dopa test should be treated with hormonal therapy in the form of ablative surgery providing they are acceptable surgical candidates. Patients with negative hormonal dependency should not be treated by endocrine manipulation, but rather, by other treatment modalities.

Combined Modality Treatment

In any review of the treatment of advanced breast cancer, one basic theme is evident. Patients responding to any form of therapy live longer than nonresponders. Patients with complete remissions have the longest survivals, while patients failing to respond to one type of therapy usually do not do well with an alternate mode of treatment. Treatment should, therefore, be directed to achieve the highest possible initial response.

Keating et al, from the City of Hope,¹⁷

demonstrated that patients initially responding to adrenalectomy had a statistically higher chance to respond to single agent chemotherapy than those failing to respond to initial hormonal management. A 40% response was noted in patients with subsequent Cytosan chemotherapy following adrenalectomy responses. Dr. Moore obtained a 58% response rate with the addition of 5-Fluorouracil in the immediate post-operative period following adrenalectomy. This can be compared to an earlier series of adrenalectomy patients reviewed by Moore treated without chemotherapy. This group was associated with a 40% response rate.

Mannes and associates¹⁸ have recently published a report on combined modality treatment. Hormonal treatment was accomplished by castration in premenopausal patients. Chemotherapy was added utilizing a proven four-drug combination, C-M-F with Vincristine. An overall response rate of 83% was noted but more importantly, a complete remission was recorded in 43 of 85 patients or 51 per cent.

A Rational Approach to Advanced Breast Carcinoma

Based on the preceding discussions, an approach to the treatment of advanced breast carcinoma can be formulated. A patient presenting with advanced or disseminated breast cancer following local treatment should have an estrogen receptor determination performed when feasible. A positive L-dopa test may be helpful in patients with painful bony metastasis when no accessible tumor is available for biopsy. Patients with indeterminate estrogen receptor protein determinations or an inaccessible lesion should be treated with the group of patients having a positive estrogen receptor assay. Patients with negative estrogen receptors should not be subjected to hormonal manipulations because of their known poor response. These patients should be treated initially with chemotherapy.

Patients with positive or indeterminate estrogen receptors, considered as suitable candidates, should undergo major ablative hormonal therapy. This therapy should include bilateral oophorectomy and adrenalectomy regardless of menopausal

state. Major ablative surgery can be performed with a low operative (30 day) mortality. In a series of 580 consecutive patients undergoing adrenalectomy at the City of Hope, this incidence was 4.3%.⁸ In our later randomized sequential series, the mortality was decreased to 2.1%.

Replacement therapy is well tolerated and can usually be accomplished by the administration of 50 mg. of cortisone acetate in two divided doses daily. The patients are encouraged to follow a 3 gm sodium diet, though electrolyte balance occasionally requires the use of 0.1 mg of Florinef every other day. This should be contrasted with the more difficult replacement therapy necessary following hypophysectomy.

Suitable candidates for major ablative surgery should be less than a physiologic 60 years of age, not manifest major cardiac or pulmonary disease that would contraindicate surgery, not present with hypercalcemia, and not have extensive hepatic or cerebral metastasis or exhibit pulmonary lymphangitic spread of their tumor. Patients not considered suitable for bilateral oophorectomy and adrenalectomy, but who have the potential to respond to hormonal manipulation (i.e., positive or indeterminate estrogen receptors or a positive L-dopa test) may be treated with additive hormonal therapy. This can be accomplished by using 15 mg of stilbestrol daily though other estrogens, androgens, or progesterones may be utilized.

In an attempt to increase the number of initial responses, the addition of concomitant chemotherapy is suggested. In the above discussion, major ablative surgery, when combined with a single agent chemotherapy, 5-Fluorouracil, increased the response rate from 40% for adrenalectomy alone to 58 per cent.⁶ A second study combining castration in premenopausal women yielded a complete remission in over 50% of patients when combined with a proven combination of chemotherapeutic agents (C-M-F + Vincristine).¹⁸

It can be theorized that a combination of effective endocrine therapy and combination chemotherapy in appropriately selected patients may produce even higher response rates. A chemotherapeutic approach similar

to the low dose intermittent C-M-F regimen described by Creech provides an effective combination with low toxicity. Studies combining multi-modality treatment similar to this are under way at the City of Hope and other institutions.

Chemotherapy may be instituted in the immediate post-operative period, usually between 10 and 14 days following surgery. A low dose intermittent schedule of C-M-F similar to that proposed by Creech may be administered on an outpatient basis without difficulty. Weekly blood and platelet counts should be routine. Urinary function tests should be performed prior to the initiation of treatment and at least monthly during therapy. This is necessary since renal insufficiency will intensify Methotrexate toxicity.

We have found this regimen to be well tolerated in the postadrenalectomy patient. Myelosuppression has been uncommon with the exception of patients undergoing radiotherapy to metastatic lesions. Dosage should be modified in these patients during and immediately after radiotherapy. Alopecia, skin reaction, hemorrhagic cystitis, and stomatitis are seen rarely, while GI side effects of nausea and emesis are common days one and eight of each course. These are easily treated symptomatically. It must be constantly noted that GI disturbances are more significant in the post adrenalectomy patient and may require adjustment of maintenance steroids.

Patients not considered candidates for hormonal treatment should be started initially on chemotherapy. A C-M-F program would again seem indicated and patients may be started on a low dose intermittent schedule. In these patients, it becomes desirable to increase the dose to obtain the highest response rate possible. One schedule utilized at our institution involves the use of 5-Fluorouracil 500 mg/M² and Methotrexate 30 mg/M² given intravenously on days one and eight, and Cyclophosphamide 100 mg/M² administered orally on days one through fourteen. Patients should be advanced slowly to these levels and the clinician must be aware that toxicity is increased proportional to the dose.

Patients with progressive or recurrent

disease following the initiation of C-M-F chemotherapy should be switched to an alternate chemotherapeutic protocol. A combination of Adriamycin and Vincristine has been shown to be effective in over one-half of patients resistant to prior chemotherapy as previously discussed. Addition of a nitrosourea such as BCNU to an Adriamycin combination may result in an increase in the response rate. The toxicity of

these agents, in particular, their marked delayed myelosuppression, should relegate their use only to the unresponsive patients. When a nitrosourea is used in combination with Adriamycin, the dosage of each agent should initially be decreased by 40% due to their similar toxicities.

References are available from the author.

Computerized Tomography of the Head — Part IV

BRAIN ATROPHY-DEGENERATION

Abstract

Computerized tomography (CT) of the head is a new, non-invasive neuroradiologic procedure which is an ideal, useful and practical screening procedure in the evaluation of dementia. CT permits a detailed study of cerebral structures and especially of the low density ventricular system and sulci. CT demonstrates an extent of the atrophic-degenerative disease process not previously possible and without distortion and it allows easy identification and precise measurement of the low density enlarged ventricles and/or sulci.

DEMENTIA

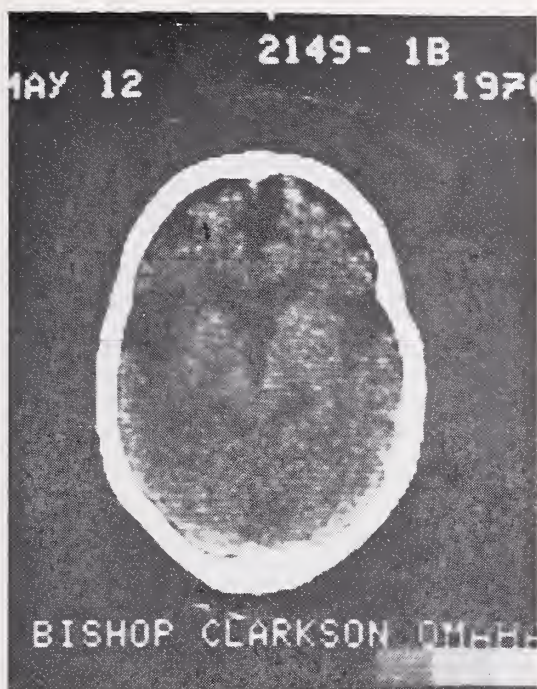
Dementia, the chronic and progressive impairment and deterioration of the higher mental status functions — intellect, memory, judgment, behavior and orientation — may have many causes. Dementia is easier to evaluate if one works through the diagnostic categories of degenerative-atrophic, infectious, toxic-metabolic, traumatic, vascular, neoplastic, and congenital diseases that may play an etiologic role. In the evaluation of dementia, computerized tomography (CT) of the head which has been previously described^{1,2} plays a very useful role as a screening procedure in diagnosing the cause of the dementia — whether it is related to brain atrophy, an intra- or extra-cerebral mass lesion, or possibly to multiple strokes

(quite rare) — after toxic-metabolic etiologies have been ruled out.³⁻¹³

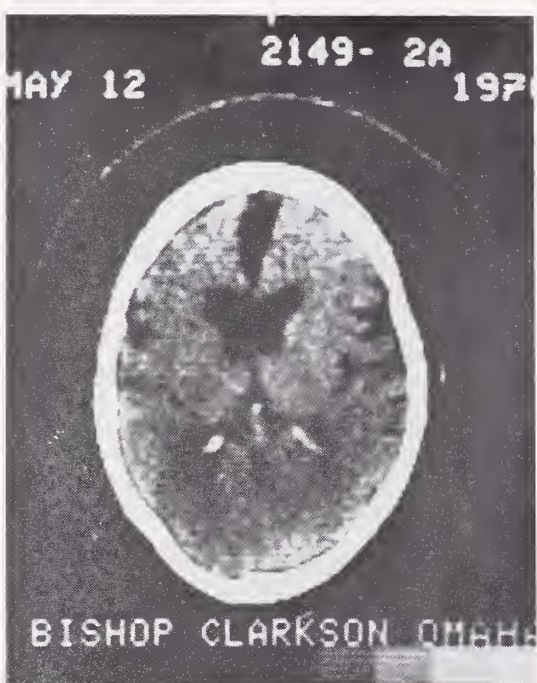
The atrophy of the brain which may manifest itself as enlargement of the ventricular system, hydrocephalus ex vacuo, and/or enlargement of the sulci with decrease in size of the gyri may be easily demonstrated by either CT or pneumoencephalography (PEG). However, the CT display of atrophy is readily seen secondary to the low density (absorption values) of cerebrospinal fluid (CSF) and not only exceeds that of PEG, but shows a greater extent of disease, can be performed quicker, simpler and without ventricular distortion and at far less patient discomfort. CT of the head may even be performed as an outpatient screening procedure.

Examples of patients with brain atrophy are illustrated in Figures 1-4. Each of the four patients, who ranged in age from 55 to 70 years old was evaluated for and diagnosed as having dementia clinically. In each case, the medical evaluation for treatable causes of the dementia was without abnormality. CT of the head demonstrated brain atrophy that in each case was felt to be the sole cause of the

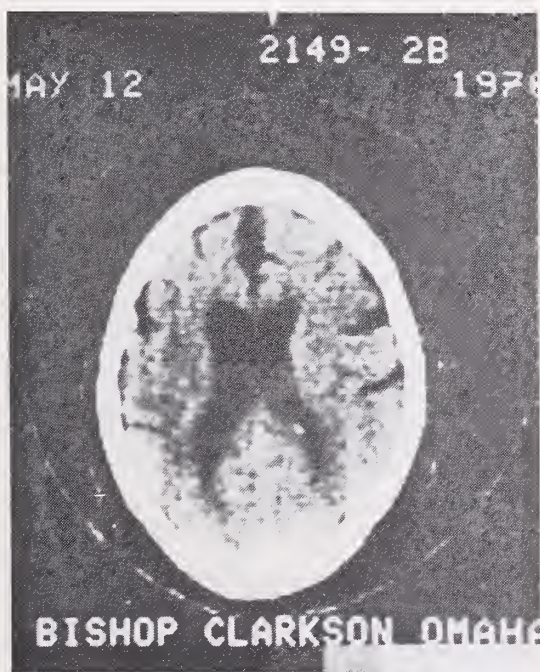
JOHN F. AITA, M.D.



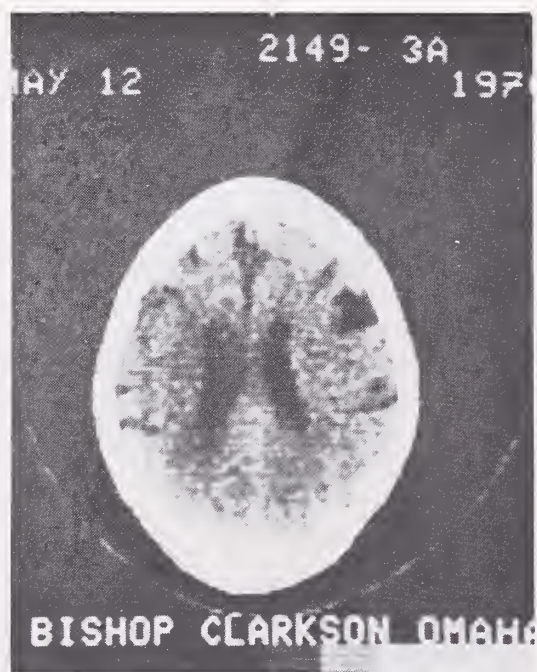
1-A



1-B



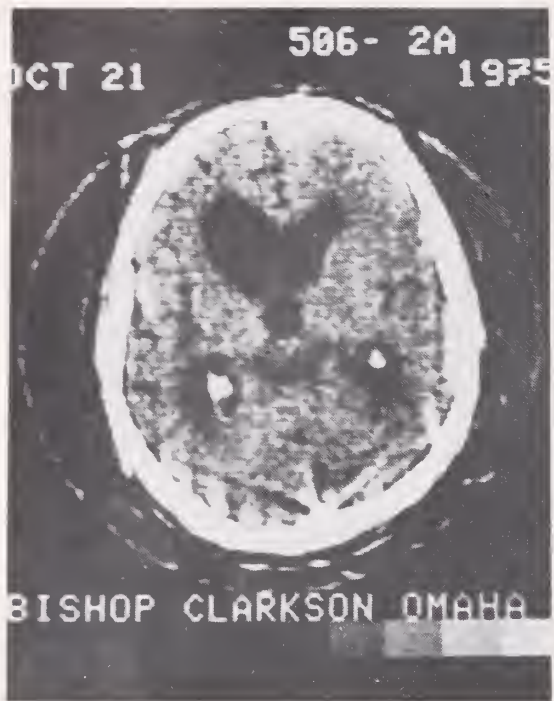
1-C



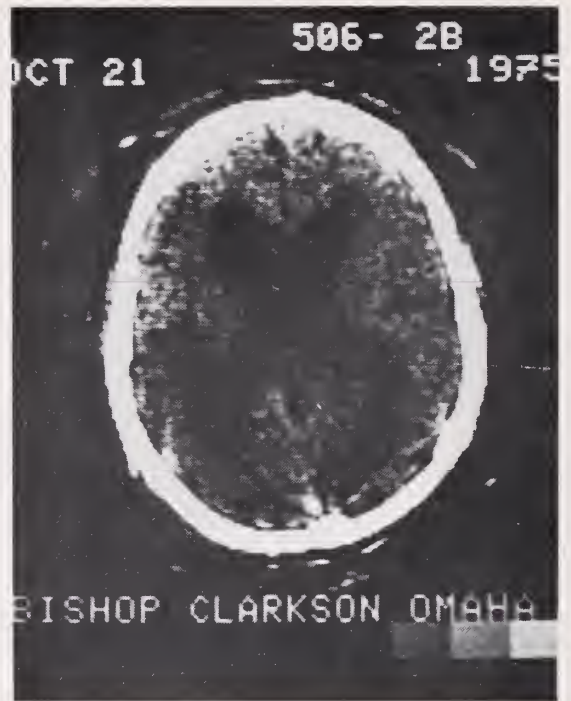
1-D

Figure 1

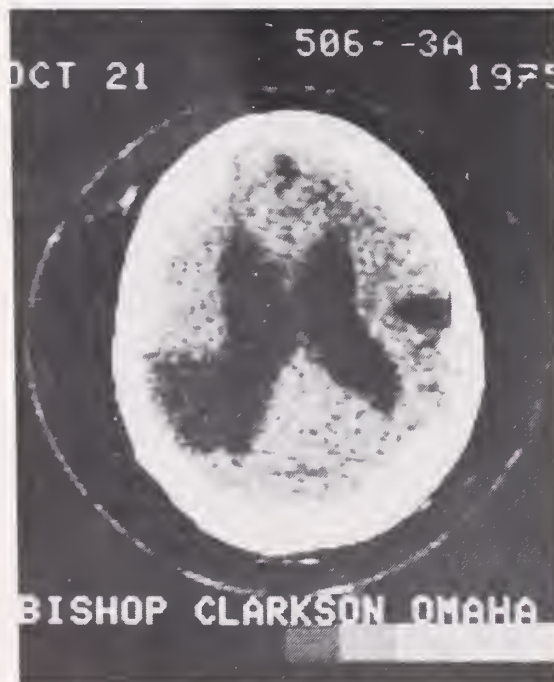
70 year old female with dementia. CT shows diffuse atrophy with enlargement of both lateral in addition to the third ventricle, the right and left Sylvian and the interhemispheric fissures, the cisterna ambiens and lateral sulci. Incidental findings include calcification of the pineal gland and the choroid plexus of both lateral ventricles.



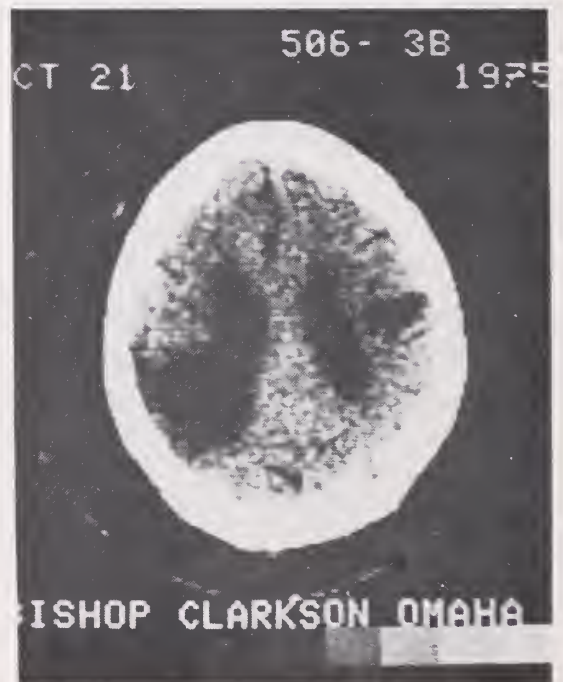
2-A



2-B



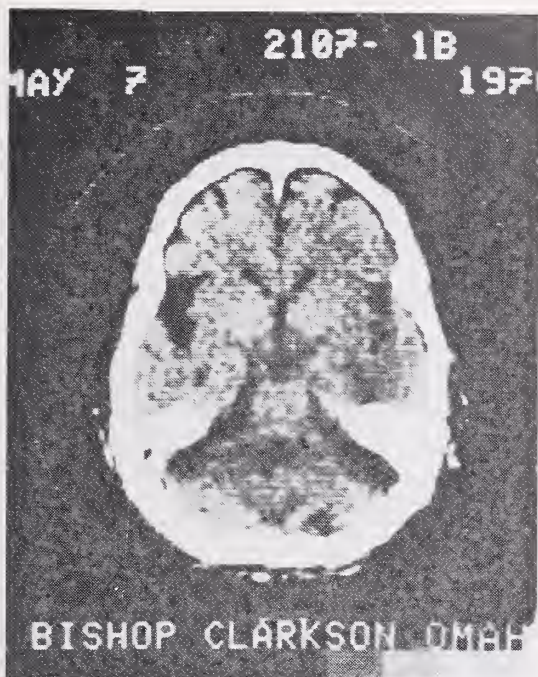
2-C



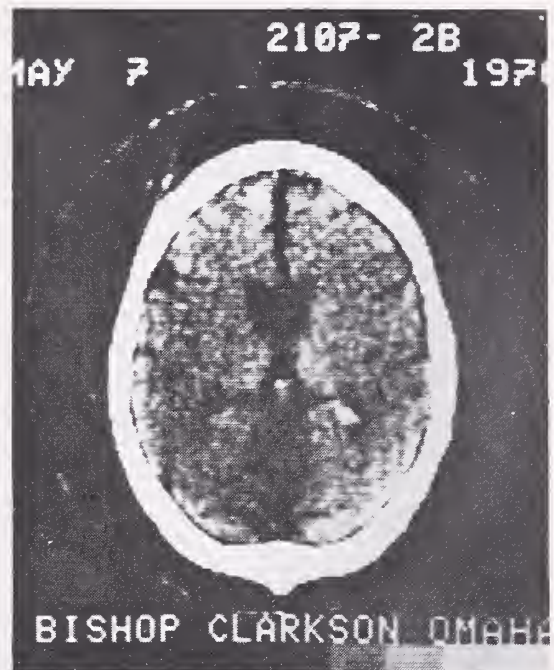
2-D

Figure 2

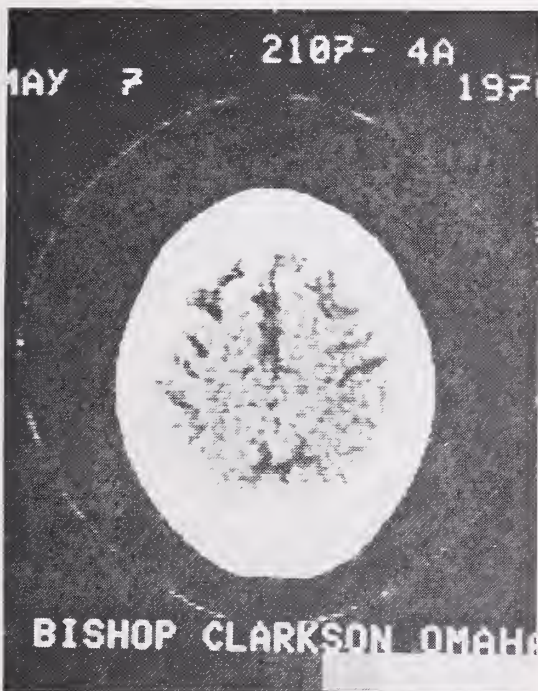
55 year old male with dementia. CT illustrates severe degeneration with marked enlargement of the third and both lateral ventricles. A left parietal porencephalic cyst and choroid plexus calcification are incidental findings.



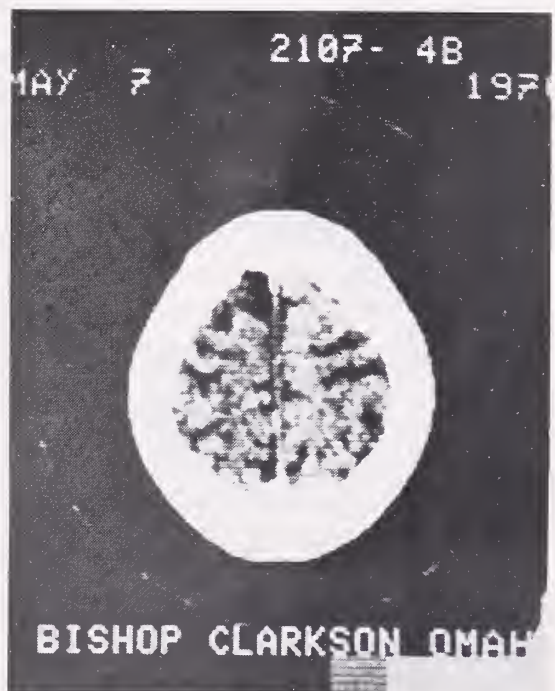
3-A



3-B

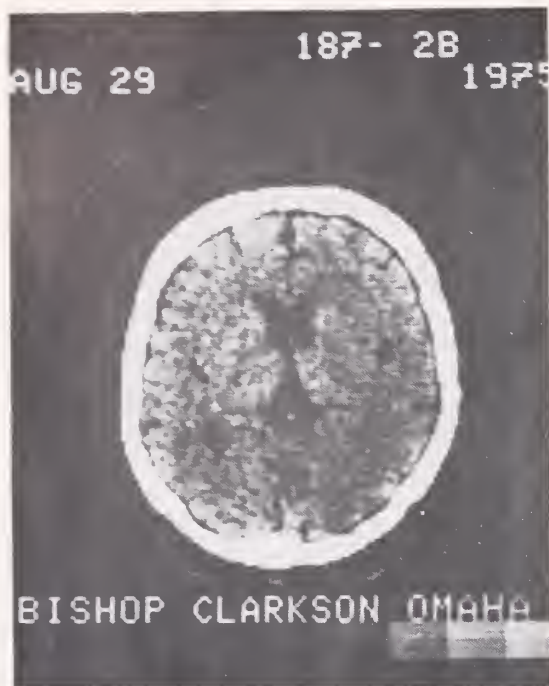


3-C



3-D

Figure 3
58 year old male with dementia. CT reveals atrophy of the cerebral gyri and enlargement of the sulci. An incidental finding is evidence of midline cerebellar atrophy.



4-A



4-B



4-C



4-D

Figure 4

69 year old female with dementia. CT demonstrates atrophy of the cerebral gyri and enlargement of the sulci.

dementia in view of the negative medical evaluation of the dementia. Thus, CT of the head helped verify a clinical diagnosis and actually demonstrated the brain atrophy as the cause of the dementia.

Figure 2 is the case of a 55 year old male with a long standing history of dementia who was shown to have the incidental finding on CT of the head of a left parietal porencephalic cyst. Figure 4 a 58 year old alcoholic shows the incidental finding of midline cerebellar atrophy.

Formerly, when pneumoencephalography was used to evaluate ventricular and sulcal enlargement one had to contend with patient discomfort and morbidity, ventricular distortion, asymmetric ventricular filling, a distribution and size of enlarged ventricles and sulci that varied with the amount of air injected, focus-film distance, the position of the head and the amount of time between air injection and film exposure, in addition to insufficient ventricular and subarachnoid space filling and the fact that "nothing can be said about eventual changes in such regions of the convexity that have not received any air."¹⁴

On the other hand, CT of the head permits an extensive visualization of the shape and exact measurement of the size of both normal and pathologically enlarged low density CSF filled ventricles and sulci under normal physiologic conditions without distortion or patient discomfort. Gyldensted and Kosteljanetz have used head CT to measure the hemispheric sulci in 44 normal adults ranging in age from 21 to 79 years and have found an average value of 1.03 mm on the Polaroid pictures.¹⁵ This correlates with the head CT study of Huckman, Fox and Topel and of Fox, Topel and Huckman in which they found the total width of the four largest cortical sulci (CS) seen in the highest three tomographic cuts to total 5 mm or less in normals on Polaroid pictures.^{3, 16}

Huckman et al and Fox et al have described a measurement of ventricular size (MVS) which consists of the distance between the most lateral portion of each of the frontal horns added to the width of the lateral ventricles in the region of the caudate nuclei; this was found to measure 15 mm or

less on Polaroid film in normals.^{3, 16} This correlates quite well with the measurements of Gyldensted and Kosteljanetz in 44 normal adults ranging in age from 19 to 79 years from whose data one can develop an average MVS of approximately 15.36 mm on Polaroid film.¹⁷ They have found that head CT measurement of the ventricular system correlates quite well with pneumoencephalographic and ventricular cast studies.¹⁷

Pathologically, Huckman et al and Fox et al have defined and categorized atrophy with enlargement of the lateral ventricles and cortical sulci as follows: mild atrophy — MVS 16-20 mm and CS 6-9 mm; moderate atrophy — MVS is greater than 20 mm and CS 6-9 mm, or MVS 16-20 mm and CS is greater than 9 mm; severe atrophy — MVS is greater than 20 mm and CS is greater than 9 mm.^{3, 16} They, also, describe cases with enlarged ventricles, MVS is greater than 20 mm, without enlargement of cerebral sulci that they feel may represent cases of normal pressure hydrocephalus or previous strokes.¹⁶

Huckman et al found good correlation between the incidence of convolutional atrophy and ventricular enlargement as demonstrated by CT and that demonstrated pathologically and by pneumoencephalography in similar population groups.³

It should be pointed out that there are many causes of dementia (*vide ante*) of which atrophy-degeneration of the brain is only one categorical cause. It must be strongly emphasized that not all patients with demonstrable brain atrophy-degeneration have dementia nor do all patients with dementia have atrophy, or if they do have dementia that the brain atrophy-degeneration is the sole cause. In fact, Huckman et al found that while 15% of their patients with moderate-severe atrophy were without dementia approximately 20% of their demented patients showed little or no head CT evidence of atrophy. Thus, the absence of CNS atrophy by CT must prompt a diligent search for a treatable cause of the dementia, remembering that occasional patients with moderate to severe atrophy by CT may, also, have a potentially treatable dementia.

Dementia is a clinical diagnosis, the cause of which may well be treatable or possibly

multiple — regardless, the etiology must be diligently searched for and CT of the head provides a safe, practical, useful and simple screening procedure for the evaluation of dementia.

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Legionnaire's Disease

ABSTRACT

An isolated case of Legionnaire's Disease was diagnosed in Nebraska. The clinical course, diagnosis, and therapy of this disease are discussed.

CASE

A previously healthy 53 year old cross-country truck driver acutely developed chills, fever, and cough on 7/19/77 while driving from California to Peoria, Illinois. Over the next three days he noted increasing dyspnea, cough, and sputum production with blood streaking. On 7/23/77 he was admitted to a western Iowa hospital. The admission chest x-ray showed an infiltrate in the left lower lobe, and treatment with Keflin and Tobramycin was begun. The dyspnea increased and the infiltrate progressed and became bilateral. On 7/27/77 the patient was admitted to the Bishop Clarkson Memorial Hospital, Omaha, Nebraska. He admitted to 2 packs per day cigarette smoking for 35 years but denied symptoms of bronchitis.

Physical examination revealed a blood pressure of 140/80, pulse of 120, respiratory rate of 48, and a rectal temperature of 103.5 F. He was disoriented, cyanotic, and in severe respiratory distress. The breath sounds were decreased over both lower lobes, with diffuse rhonchi and coarse rales throughout both lungs. The jugular venous pulse was normal, and no gallops or murmurs were heard. The abdomen was distended with decreased bowel sounds. There was tenderness in the right upper quadrant. No abdominal organ enlargement was noted.

Laboratory work on admission revealed a Hgb of 13.3 gm and a WBC of 16,400 with 3% juvenile neutrophils, 82% bands, 11% segs, 3% lymphs and 1% eosinophils. The urinalysis was normal. The following chemistries were obtained on admission: creatinine 1.6 mg/dl, total bilirubin 2.0 mg/dl, alkaline phosphatase 140 mU/ml, LDH 423 u/l, SGOT 169 u/l, glucose 124 mg/dl, sodium 128

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mEq/l, potassium 3.8 mEq/l, and BUN 31 mg/dl. Arterial blood gases were obtained on a Venturi-type mask with an 0.4 FIO₂: PaO₂ 50 mm/Hg, PaCO₂ 30 mm/Hg, and pH 7.49. The admission chest x-ray was interpreted as showing bilateral alveolar consolidative pneumonia which had progressed since the outside x-rays of 7/23/77 and 7/25/77 (Figure 1).

Shortly after admission it was apparent that the patient would require ventilatory support because of his increased work of breathing and progressive hypoxemia. Therefore, he was intubated with a low compliance cuffed oral endotracheal tube, and ventilated with an Ohio 560 volume ventilator modified with an Emerson positive end-expiratory (PEEP) pressure valve and a high flow intermittent mandatory ventilation (IMV) system. With an FIO₂ of 0.6 and 10 cm PEEP the PaO₂ stabilized around 60 mm/Hg.

Initial sputum Gram stains showed no WBCs and no organisms. Gentamicin and methicillin were started because of the possibility of a bacterial pneumonia. When sputum cultures showed no Gram negative pathogens on the second hospital day, the gentamicin was stopped and erythromycin begun. The patient's fever gradually decreased from peaks of 105-106°F rectally on

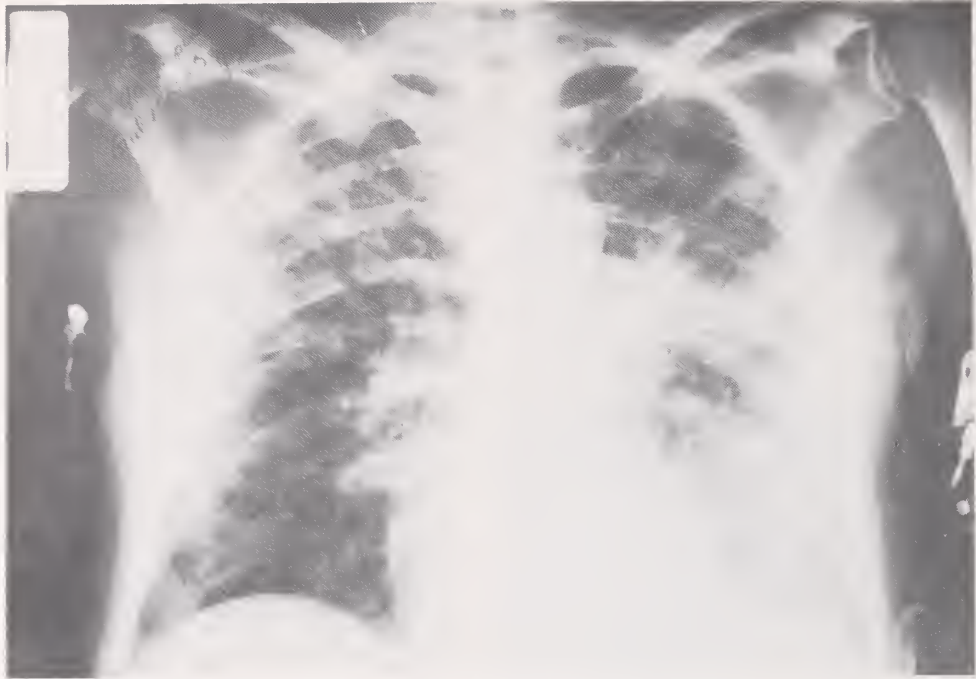


Figure 1



Figure 2

admission to normal by day six. His chest x-rays and arterial blood gases improved, and on the seventh hospital day he was extubated and supported with oxygen by mask. A chest x-ray on hospital day nine showed significant improvement (Figure 2).

Renal and hepatic function deteriorated as respiratory failure subsided. The creatinine rose to 5.8 mg/dl on the sixth hospital day and has remained moderately elevated after total recovery from the respiratory illness. The etiology of his chronic renal failure is

presently unknown. The liver initially enlarged to a total span of 23 cm to percussion. It was tender to palpation. The bilirubin rose to 5.6 mg/dl on the tenth hospital day. Since that time all liver functions have returned to normal.

Multiple sputum and blood cultures were obtained. No bacterial, fungal, or mycobacterial pathogens were isolated. Cold agglutinins were 1:4, and mycoplasma complement fixations were negative. Serologic tests for rickettsial disease, leptospirosis, coccidiomycosis, and histoplasmosis were negative. Acute and convalescent sera were submitted to the Center for Disease Control in Atlanta, Georgia, for Legionnaire's disease antibody, and they reported a rise in titer from 1:16 to 1:1024 which is felt to be diagnostic of Legionnaire's Disease. The patient has since returned to Peoria, Illinois, and is expected to make a complete recovery and return to work in the near future.

DISCUSSION

In the summer of 1976 there was an outbreak of pneumonia in Philadelphia which primarily involved persons attending an American Legion Convention. There were ultimately 180 cases of Legionnaire's Disease resulting in 29 deaths.

In January, 1977, the Center for Disease Control in Atlanta, Georgia, isolated a gram-negative bacillus from guinea pigs inoculated with material from a case of the disease.¹ The organism grew in the yolk sacs of embryonated eggs, but not on conventional bacteriologic media. In addition, the CDC developed an indirect fluorescent assay for measuring antibody to the organism. Eighty of 117 sera available from the Philadelphia outbreak demonstrated either an elevated baseline titer or a fourfold rise in titer to the Legionnaire's disease bacterium.

This patient presented acutely with symptoms similar to those who developed Legionnaire's Disease in Philadelphia: fever, chills, malaise, and cough. About 40% of those who became ill in Philadelphia had an underlying disease such as diabetes mellitus or malignancy; this patient did not. His x-ray

picture was that of a gradually advancing pneumonia involving multiple lobes. This is reportedly typical of Legionnaire's disease, but is nonspecific. Our patient demonstrated a marked polymorphonuclear leukocytosis, a finding which is not uncommon in Legionnaire's disease.

Liver function abnormalities are not uncommon in this disease, as this patient demonstrated. Liver biopsy characteristically reveals centrilobular fatty changes. Renal failure is not usually part of the syndrome.

Tests of minimum inhibitory concentration of various antibiotics to the Legionnaire's disease agent have been performed on at least one strain.² All antibiotics except vancomycin, tetracycline, and methicillin were adequate in vitro. Erythromycin also acts in vivo in guinea pigs, and is probably the drug of choice at present. Erythromycin appeared to gradually improve the clinical course in this case.

Serological evidence suggests that Legionnaire's bacterium is responsible for the Philadelphia outbreak of pneumonia in 1976 as well as some cases of sporadic pneumonia. Legionnaire's disease can be most easily confirmed by submitting acute and convalescent (obtained at least three weeks after the first sample) sera to the CDC via the Nebraska State Health Lab in Lincoln. Although the organism is difficult to grow on artificial media, the CDC recommends³ the use of Mueller-Hinton or GC agar containing 1% hemoglobin and 2% enrichment when isolation from clinical specimens is attempted.

This is the first reported case of Legionnaire's Disease in Nebraska. While it is an uncommon entity, physicians should consider Legionnaire's Disease as a possible etiology in cases of pneumonia of obscure origin.

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Down Memory Lane

The symptoms of diabetes in children are identical with those in adults.

The human race has always valued highly health and strength but only recently as history goes has man come to appreciate that the state has a deep interest in the health of its citizens.

The gynecological clinic had but one patient during the two winters I attended school.

Thirty states now have women's auxiliary state medical associations.

The danger from the ether anesthetic is that you will start something which leaves its effect upon the patient. With local, you get away from that entirely.

About 75% of children with diabetes are unable to progress on diet alone.

Health training is at least as essential a component of the child's education as arithmetic or grammar.

They found that 6 cc. of iodized oil may be injected into the femoral artery of the average man with perfect safety, and yield good roentgenograms. This is not only an excellent but also a harmless means of vascular exploration, particularly of the vessels of the lower extremity.

The medical treatment of thrombo-angiitis-obliterans has not been heralded as a "howling success."

Go to a dentist and he will charge you \$10.00 an hour for his service, and it is worth it. So how can he spend such precious time teaching students? But it is different in this College of Medicine.

Nebraska State Medical Journal
January, 1928

President's Page

IS IT TRUE?

I attended a meeting recently wherein the medical profession was subjected to a lot of accusations. I said to myself, can this be true?

First off, I was told, we no longer have the kind, sympathetic, understanding concern that symbolized the good old family doctor. That image no longer exists. We have become insensitive, according to the accusation, as compared to the family doctor of the good old days. No compassion, just a cold scientific doctor that never radiates the warmth that should be in our hearts. No criticism of our scientific knowledge, just our attitude.

It was said that in an emergency, the health profession was more concerned about getting the third party carrier forms filled out than taking care of the emergency. We are said to be more concerned about whether we will get paid than in rendering service. Can this be true?

It was told that some go so far as to insist on cash payment before any service is rendered. It is also said that third party forms are not signed until the bill is paid in full by the patient. Is this true?

With the change in attitude, our integrity is being eroded and so undermined that the patient is now demanding a second opinion. We no longer have his confidence. In the good old days the doctor was the one obtaining another opinion but now the consumer is forcing the issue upon us. And if two opinions are not enough they demand a third. They say we have not been honest with them, suggesting operations and treatment when they were not necessary. Oh, how irresponsible we have been accused of being. Say it isn't true.

Then there is waiting. We are accused of making the patient wait needlessly, making him wait to emphasize how much we are in demand and how important we are. Can this be true? I know that doctors, to avoid this, work endlessly on time and appointment



schedules and on occasion, when a patient is made to wait, it is because of an emergency or unexpected commitment. However, I know when this happens an extra minute or two is spent to apologize for the delay and explain that we know this time is valuable the same as ours. This is the public relations we have always practiced.

It was hard to listen to this type of rhetoric that was being leveled at us by the people we are serving. I would hope there is a modicum of kindred spirit of old left in the practice of medicine and that these accusations are not true.

If we are all being accused of this way of practice, maybe we should make it that way so it would be true and then we couldn't be falsely accused. No that would not be right. We have too much at stake to let it happen.

Let us upgrade our relationship with the patient, establish more rapport and give no inroad for this type of derogatory remarks to be promulgated. If there is a way to be a better doctor in the eyes of our patient, let us do it. Keep our time honored profession at the highest attainable level. Show every patient the concern you would expect if you were the patient.

Arnold W. Lempka, M.D.



The Auxiliary

MUSEUM AREA BEING PREPARED FOR HEALTH GALLERIES

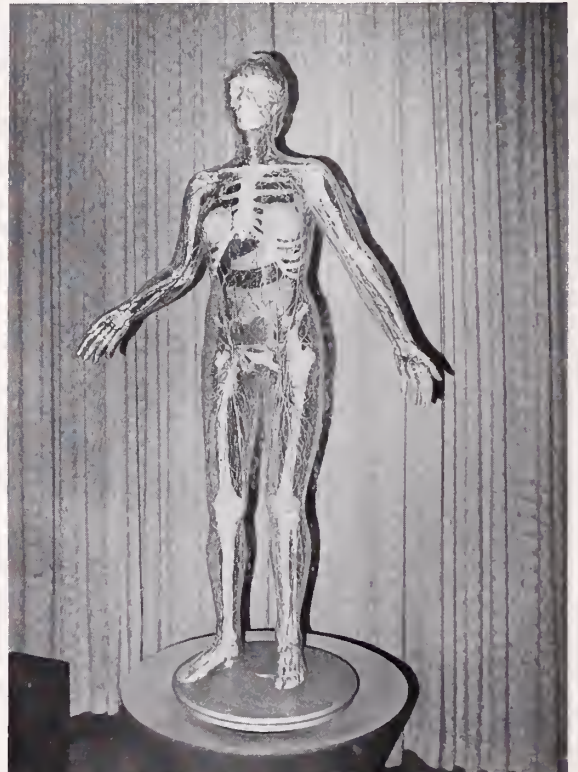


The halls of the State Museum are echoing with the sounds of hammers, electrician drills, and excited voices! This activity is signaling the preparation of the museum area for the construction of the first phase of the proposed Health Galleries.

The more than 44,000 school children who visit the museum yearly will have the opportunity to view Ceres in her new surroundings and share in the pilot programs that are being developed.

PLEDGES from over 200 members of the medical community have made it possible for these initial steps to be taken. Each new pledge will be a step toward making the health galleries a reality.

* * *



We give/pledge for the development of the Health Galleries.
MAKE YOUR CHECK PAYABLE TO: Health Galleries, Account #429
Mail to: NU Foundation, P.O. Box 30186, Lincoln, Nebraska 68503

Name
Address
.....
.....

Picture Gallery

1977 NMA FALL SESSION



House of Delegates Reference Committees.



House of Delegates Reference Committee.



House of Delegates Reference Committee.



House of Delegates Reference Committee.



House of Delegates Reference Committee.



Doctor Herbert E. Reese presenting Reference Committee Report.

Picture Gallery

1977 NMA FALL SESSION



NMA House of Delegates.



Doctor William J. Chleborad presenting Reference Committee Report.



Doctor James G. Carlson presenting Reference Committee Report.



Doctor Richard A. Cottingham presenting Reference Committee Report.



Vertigo spoils the view.

Most Widely Prescribed—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

Relief of Nausea and Vomiting—Antivert/25 can relieve the nausea and vomiting often associated with vertigo*.

Dosage for Vertigo*—The usual adult dosage for Antivert/25 is one tablet t.i.d.

SUMMARY OF PRESCRIBING INFORMATION

INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
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Antivert[®]/25 
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for vertigo*

**THE STRENGTH TO
OVERCOME EXCESSIVE
ANXIETY IN THE
ELDERLY CARDIAC
PATIENT.**

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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(diazepam)[®]

2-MG TABLETS B.I.D. OR T.I.D.

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TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE **DYAZIDE®**

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

Warning

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

*** Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids).

Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+ . Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions:

Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions;

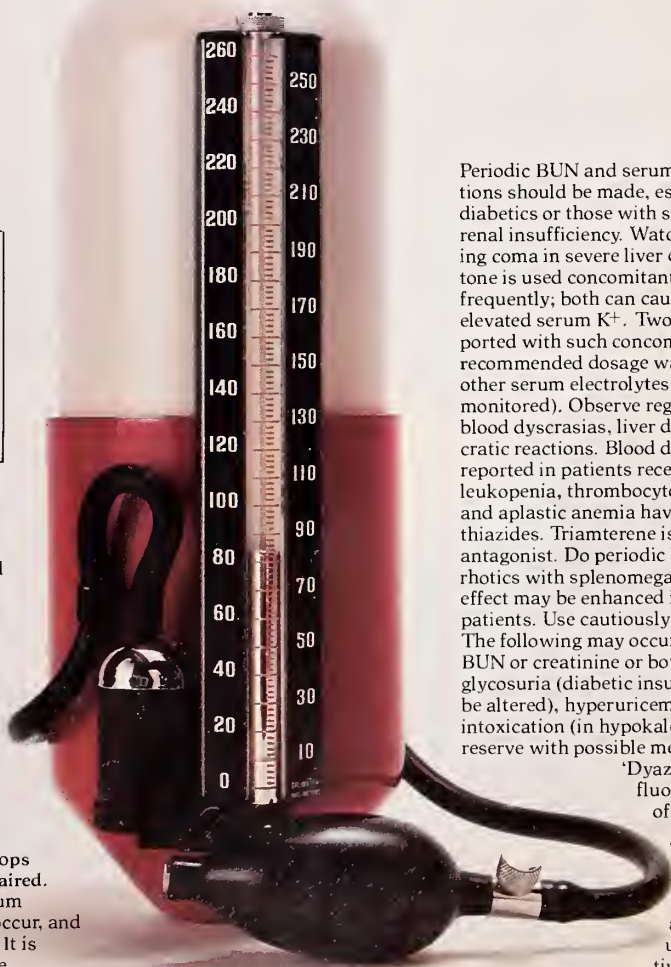
nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

**FOR LONG-TERM CONTROL
OF HYPERTENSION.*
SERUM K^+ AND BUN SHOULD
BE CHECKED PERIODICALLY.
(SEE WARNINGS SECTION.)**

SK&F CO., Carolina, P.R. 00630

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Make check payable to:
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*House of Delegate action October 1976, recommended	listed in the Nebraska Medical Journal. All
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(Continued on next page)



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Our Medical Schools

Student research.

The University of Nebraska Medical Center in Omaha will host the 1978 Midwest Student Medical Research Forum April 6, 7, and 8, 1978.

The forum is open to students from health professions schools throughout the nation.

Students who wish to enter the competition must have their abstracts written on the American Federation for Clinical Research forms and submitted to the UNMC Center for Continuing Education, 42nd and Dewey Streets, Omaha, NE (68105) no later than February 15.

Between Cases

Section On Pathology.

The inner diaphragm is punctured. The ticker has carbureted.

Leslie Miner: Psychic.

I Thought It Was A Girl's Name.

ELISA: enzyme-linked immunosorbent assay.

Say That Again.

He was obtunded mentally but was alert.

Definition.

A conservative: someone who thinks nothing should be done for the first time.

The Chart.

Patient was having colonic spasms of the neck and face and lower abdomen.

How To Practice Medicine.

A drug is a substance which when injected into a rat will produce a scientific report.

Words We Can Do Without.

An idea whose time has come, legend in his own time, throw out the baby with the bath water.

The Hospital.

Why should good work smell of death?

Roberta Silman: Company.

Syndromes You May Have Missed.

Locked lung, cheshire cat syndrome, disaster syndrome.

On Diagnosis.

Alec smiled: doctors so often do when their grim diagnosis is proved right.

Paul Theroux: Dengue fever.

A What:

I want to correct a factoid that seems to be entering the discussion of medical care costs with increasing frequency.

News release.

Heard On TV.

I want to re-emphasize again.

The Patient.

The barrel-chested giant was gone, and all that was left was pain.

C. Larson: Muir's blood.

Radiology.

X-ray shows evidence of fusion at the fused joint.

Quote Unquote.

It is always a silly thing to give advice, but to give good advice is absolutely fatal.

Oscar Wilde.

—F.C.

Books



Handbook of poisoning; by Robert H. Dreisbach, M.D.; ninth edition; 559 pages; limp cover, \$8.00; published September 1977 by Lange Medical Publications, Los Altos, California.

This book first appeared in 1955; it is small enough to fit into a large pocket, but it will better rest on your

desk. It is divided into 6 sections and further into 36 chapters. There are tables, an appendix, and a good index.

It is well written, the type is good; it is recommended.

—F.C.

Coming Meetings

NEBRASKA MEDICAL ASSOCIATION ANNUAL SESSION — April 30 - May 3, 1978, Lincoln Hilton Hotel, Lincoln, Nebraska.

THE FIRST INTERNATIONAL SYMPOSIUM OF THE INTERNATIONAL COLLEGE OF PEDIATRICS — June 18-22, 1978, Finlandia Hall, Helsinki, Finland. Plenary Sessions, Symposia, Round-table discussions, Free papers. George D.

Maragos, M.D., M.Sc., Associate Professor of Pediatrics, Creighton University Medical School, Omaha, Nebraska, 68108, USA.

AMERICAN MEDICAL ASSOCIATION — Annual Convention, June 17-22, 1978, St. Louis, Missouri.

NEBRASKA MEDICAL ASSOCIATION FALL SESSION — September 21-23, 1978, Lincoln Hilton Hotel, Lincoln, Nebraska.

Physicians' Classified

Advertisements in this column are run at a rate of twenty cents per word with a minimum of \$10.00 per insertion. Copy must be received by the fifth of the month preceding date of publication and should not exceed 50 words. Each advertisement will be taken out following its first appearance unless otherwise instructed. Where numbers follow advertisements, replies should be addressed in care of The Nebraska Medical Journal, 1902 First National Bank Building, Lincoln, Nebraska 68508.

FAMILY PHYSICIAN — Opportunity to join six-man group in beautiful Northwest Iowa. New clinic building of 10,000 square feet is located next door to 88-bed county hospital. Unusually progressive community of 10,000 offers 3,000 acre lake, 85 acres of parks and recreation, local liberal arts college, and many family interest features. Generous salary with incentive, malpractice insurance, liberal vacation and seminar time, partnership in one year. Contact: D. A. Pritchard, Administrator, Buena Vista Clinic, 620 Northwestern Drive, Storm Lake, Iowa 50588.

STAFF PHYSICIAN FOR FAMILY PRACTICE RESIDENCY PROGRAM. Duties include teaching and supervising residents, plus direct patient care. Will join two-full-time physician faculty in new model office. Approved program is affiliated with University of Iowa College of Medicine. Good salary and fringe benefit package, plus opportunity for postgraduate study. Contact: Charles A. Waterbury, M.D., Program Director, 441 East San Marnan Drive, Waterloo, Iowa 50702.

EMERGENCY ROOM PHYSICIAN — Immediate opening for qualified physician. New hospi-

tal; new modern E.R. Dept. Good working conditions with all supportive services. Four - twelve-hour days per week. No weekends. Contact: Administrator, Lutheran Memorial Hospital, 2116 West Faidley, Grand Island, NE 68801 (308) 382-3890.

FOR LEASE — Modern office space in medical building — ideal for general practitioner or specialist — can accommodate two doctors easily — 2,000 sq. ft. — interior completely finished — previous occupant retired — lower level occupied by Dentist — ample parking — heavily populated area, centrally located to all major hospitals. Write: L. J. Kelley, DDS, 2821 North 56th Street, Omaha, Nebraska 68104.

PSYCHIATRIC RESIDENCY: Vacancies for (PG2 through PG4 only) position for January 1, 1978, and July 1, 1978, for those who have a regular Iowa license or can obtain one by reciprocity or via FLEX. Prepare for career in private practice, community clinics or hospital-based psychiatry. Emphasis on close supervision of intensive individual and group psychotherapy, OPD, Children's Unit, Adolescent Unit. Neurology affiliation with University of Iowa. The stipends are: 1st Year, \$22,360; 2nd Year, \$23,478; 3rd Year, \$24,674. Intensity and diversity of training program appreciated best by personal visit. T. B. McManus, M.D., Superintendent, Mental Health Institute, Cherokee, Iowa 51012. Equal Opportunity Employer. Call collect 712/225-2594.

WashingtonNotes

Congress.

With the exception of a few high-priority items, Congress has finished its business for this year. Still to be completed this session are boosts in Social Security taxes, the Administration's energy bill, and the Health Education and Welfare Department appropriation bill. Most hearings are over. Most Congressmen have gone home.

Among the health measures definitely put off until next year are the Administration's disputed hospital cost containment plan, the clinical laboratories bill extending federal authority, and a revision of the Nation's drug laws.

One of the final bills approved by the lawmakers during their regular session was an 18-month postponement of the proposed ban on saccharin by the Food and Drug Administration. Under the legislation, saccharin products must bear labels warning that the product has caused cancer in test animals.

Another last-minute approval was for a one-year extension of the special pay provisions for Veterans Administration physicians.

In a somewhat unexpected action, House and Senate conferees reached last-minute agreement on the controversial medical school capitation *quid pro quo* for admission of foreign-trained U.S. students. The compromise will repeal that condition after one year, but require a 5 percent increase in third-year enrollment in the meantime.

Cost containment.

The AMA, American Medical Association, the American Hospital Association, and the Federation of American Hospitals have accepted an unusual challenge from Congress and agreed to develop a voluntary hospital and health care cost containment program.

James H. Sammons, M.D., Executive Vice President of the AMA; President John Alexander McMahon of the AHA; and Director Michael Bromberg of the FAH made the following joint statement:

"Our three organizations, at the instruction of our respective officers, are beginning now to organize a national steering committee of hospital people, doctors, insurers, consumers and others with a major stake in hospital cost containment. We will ask this committee, which we expect to have its first meeting within the next several weeks, to develop the goals and mechanisms, first, of a voluntary program to reduce the rate of increase in hospital costs, and, second, of a voluntary program to reduce the rate of increase in health care costs as a whole. We will also encourage the development of similar steering committees at the state level to help implement these programs."

Second opinions.

The federal government plans a major campaign to urge the American public to seek opinions on surgery.

The unusual and precedent-setting program involving patients' dealings with physicians will be conducted by the HEW Department. Both Medicare and Medicaid programs will be geared to encourage second opinions.

The policy was announced by Hale Champion, HEW Under Secretary, before the House Commerce Subcommittee on Oversight and Investigations.

The Department has been instructed to remove the remaining legal barriers to patient-elected second opinions in Medicare. States will be requested to implement as quickly as possible active second opinion programs for Medicaid.

If two physicians disagree, Medicare will pay for a third opinion if the patient desires one, according to HEW.

At present, Medicare will pay for a second surgical opinion if the physician agrees to the advisory or orders it. But the physician's acceptance is at present mandatory. In the future the patient would be reimbursed for a second opinion if the initial physician believes it unnecessary.

One question to be answered is whether the patient must receive a negative response on a second opinion from the first physician, or simply could go off on his own to get a second opinion without even asking the physician.

Labelling & residencies.

Rep. Tim Lee Carter, M.D., (R-Ky.) has introduced legislation sought by the AMA dealing with funding for residencies in preventive medicine and labelling of prescription drug containers.

The labelling bill would require that drug containers as dispensed to patients carry the established or trade name together with the quantity and strength of the drug. The AMA said that in cases of medical emergency it is often important for attending medical personnel to know the name, strength and contents of any drugs a patient is taking.

Under the bill introduced by Dr. Carter, ranking GOP member of the House Commerce Subcommittee on Health, an exception to the labelling is provided when the physician decides that for medical or emotional reasons it is in the best interest of the patient that the information not be made known to him or indirectly to the patient's family or associates.

The other bill introduced by Rep. Carter calls for an amendment to the Health Manpower Law to provide funding for residencies in preventive medicine. Specific program funding for such residencies was not included in the Health Manpower Law as passed.

Scholarships.

President Carter has signed into law good news for medical students on federal scholarships. Their stipends will now be freed from federal income taxation.

The exemption applies both to Armed Services health professions scholarships as well as the Public Health Service's National Health Service Corps scholarship program. Some 10,000 medical students get a break as a result.

Generic & brand.

There are no big differences between generic and brand drugs according to the Commissioner of the Food and Drug Administration Donald Kennedy, PhD. Dr. Kennedy told the Senate Monopoly Subcommittee that some of the larger pharmaceutical houses frequently buy products from smaller generic producers and sell them under the larger firm's brand name.

HMOs.

The Carter Administration's new-found love affair with health maintenance organizations (HMOs), an old flame of the Nixon Administration — is flourishing.

HEW Secretary Joseph Califano is inviting 500 large corporation representatives to Washington, D.C., Feb. 7 to make a pitch for their establishment of HMOs for their employees to replace fee-for-service, regular health insurance plans.

He made the announcement at a ceremony in New York City certifying the huge, 3.25 million-member Kaiser-permanente prepaid health plan as an HMO. As a result, Kaiser becomes eligible for certain federal loans and loan guarantees and has an easier job dealing with Medicare and Medicaid contracts with the government.

Severe Radiation Injuries of the Lung — B. Roswit (Veterans Administration Hosp, Bronx, NY 10468) and D. C. White Am J. Roentgenol 129:127-136 (July) 1977.

The lung is a radiosensitive organ whose limited tolerance must be treated with great respect in the radiation management of malignant tumors in the thorax. Severe radiation pneumonopathy can cripple and kill as the outcome of faulty judgment, error, accident, or calculated risk in an effort to control a locally advanced cancer. The onset of severe pneumonopathy is usually insidious, weeks after completion of treatment; yet the final outcome in the individual patient is unpredictable. Radiation pneumonopathy may masquerade as infectious pneumonitis, recurrent cancer, lymphangitic spread, or metastasis. Treatment of the acute exudative reaction must include, above all, the prompt and maintained use of high dose corticosteroid therapy.

Ligation of the Patent Ductus Arteriosus in the Newborn Intensive Care Unit — S. C. Oxnard et al (H. D. Rittenberg, Dept of Pediatrics, Univ of Utah Medical Center, Salt Lake City, UT 84132) Ann Thorac Surg 23:564-567 (June) 1977.

During a two-year period, 21 premature infants (weight at birth, 680 to 2,340 gm) had operative closure of patent ductus arteriosus (PDA). The first six infants had ligation performed in the operating room (OR); the subsequent 15 had ligation in the Newborn Intensive Care Unit (NBICU). There were no immediate postoperative deaths. Two infants died from problems present preoperatively within 30 days postoperatively. There were no infections. Technique in the NBICU utilizes an open warmer with local anesthesia and a paralyzing agent. By eliminating transportation to the OR one avoids problems with thermoregulation, loss of lines, malfunction of monitors, poorly controlled ventilation, and fluid overload. Additional advantages to ligation in the unit are that the infant is already monitored, intubated, and on a respirator, and that venous and usually umbilical arterial lines are in place. At the conclusion of operation, management is returned to the neonatologists for optimal continuity of care.

Vitamin B6 Treatment of Gestational Diabetes Mellitus — W. N. Spellacy et al (Univ. of Florida College of Medicine, Gainesville, FL 32610) Am J. Obstet Gynecol 127:599-602 (March 1) 1977.

Thirteen women with late pregnancy gestational diabetes mellitus were tested with an intravenous glucose tolerance test and blood glucose and plasma insulin levels were measured. Each woman was then treated with 100 mg of vitamin B₆ daily for two weeks and the intravenous glucose tolerance test was then repeated. There was a statistically significant improvement in the glucose tolerance curve after the vitamin B₆ treatment, with lowering of blood glucose levels at all points on the curve except for the five-minute value. This glucose effect occurred despite an unchanged or lowered plasma insulin level. These results suggest that a relative deficiency in vitamin B₆ is associated with some cases of gestational diabetes mellitus and that the replacement of this vitamin improves the metabolic state. The low vitamin B₆ levels appear to alter metabolic pathways which result in a lowering of the biologic activity of endogenous insulin.

Episodic Nocturnal Wanderings Responsive to Anticonvulsant Drug Therapy — T. A. Pedley and (C. Guilleminault, Sleep Disorders Clinic, Stanford Univ Med Center, Stanford, CA 94305) Ann Neurol 2:30-35 (July) 1977.

Six patients between the ages of 17 and 32 years had unusual sleep-walking episodes characterized by screaming or unintelligible vocalizations; complex, often violent automatisms; and ambulation. Two or more attacks could occur in a single night and were most common in the early morning hours. Family and personal histories did not show epilepsy, psychiatric disorders, or (with one exception) previous somnambulism. Electrographic investigation revealed that all patients had normal waking-sleep cycles but four patients had epileptiform abnormalities on their electroencephalograms. All patients were treated with either phenytoin or carbamazepine, with cessation of the abnormal nocturnal behavior during follow-up periods, ranging from nine to 48 months.

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider

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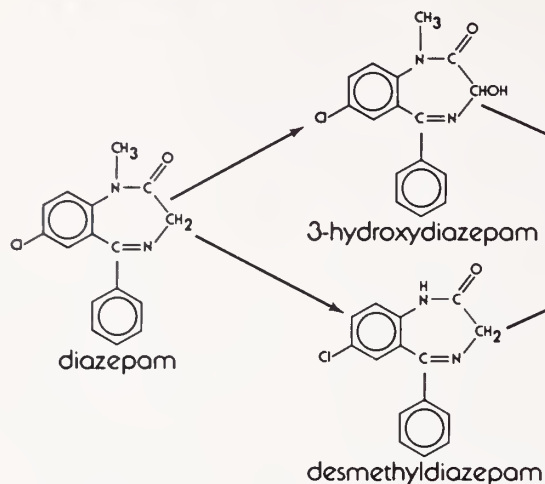
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Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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A Modern Approach to Management of Pregnant Diabetics: A Two-Year Analysis of Perinatal Outcomes — M. T. Gyves et al (I. R. Merkatz, Univ Hospitals of Cleveland, Cleveland, OH 44106) *Am J Obstet Gynecol* 128:606-616 (July 15) 1977.

Increased understanding of maternal-fetal carbohydrate homeostasis together with modern perinatal technology now provides a more rational basis for obstetric management of the pregnant diabetic patient. These concepts were applied in the care of 96 diabetic pregnant women over a two-year period and compared with prior experiences with the same group of women. The perinatal mortality was reduced from 13.5% to 4.2%, and the rate of macrosomia (infants large for gestational age) was reduced from 30.9% to 17.7%. Patients with gestational diabetes, with a prior loss rate of 8.3%, suffered no losses in the current series.

Effects of Oral Zinc and Vitamin A in Acne — G. Michaelsson et al (Univ Hosp, Uppsala, Sweden) *Arch Dermatol* 113:31-36 (Jan) 1977.

The effects of oral zinc sulfate (corresponding to 135 mg of zinc daily) alone and in combination with vitamin A (300,000 international units) daily on acne lesions were compared with those of vitamin A alone and of placebo. The number of

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comedones, papules, pustules, and infiltrates were counted at each visit. After four weeks, there was significant decrease in the number of papules, pustules, and infiltrates in the zinc-treated groups. The effect of zinc plus vitamin A was not better than zinc alone. After 12 weeks of treatment, the mean acne score had decreased from 100% to 15%.

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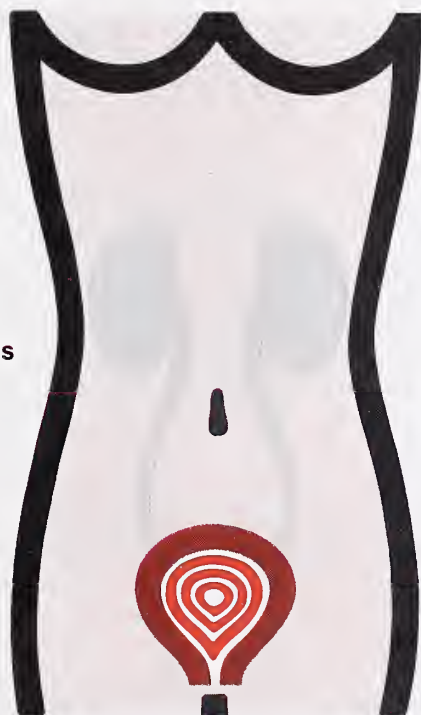
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□ **Appropriate antibacterial therapy:** up to three days therapy with Azo Gantanol, then 11 days with Gantanol[®] (sulfamethoxazole), 0.5 Gm tablets.

*Nonobstructed; due to susceptible organisms



Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: Blood dyscrasias (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura,

hypoprothrombinemia and methemoglobinemia); allergic reactions (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); G.I. reactions (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); CNS reactions (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); miscellaneous reactions (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. Usual adult dosage: 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

Note: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.



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TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE **DYAZIDE®**

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* Warning

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. A lequate information on use in children is not available.

Precautions. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids).

Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

'Dyazide' interferes with fluorescent measurement of quinidine.

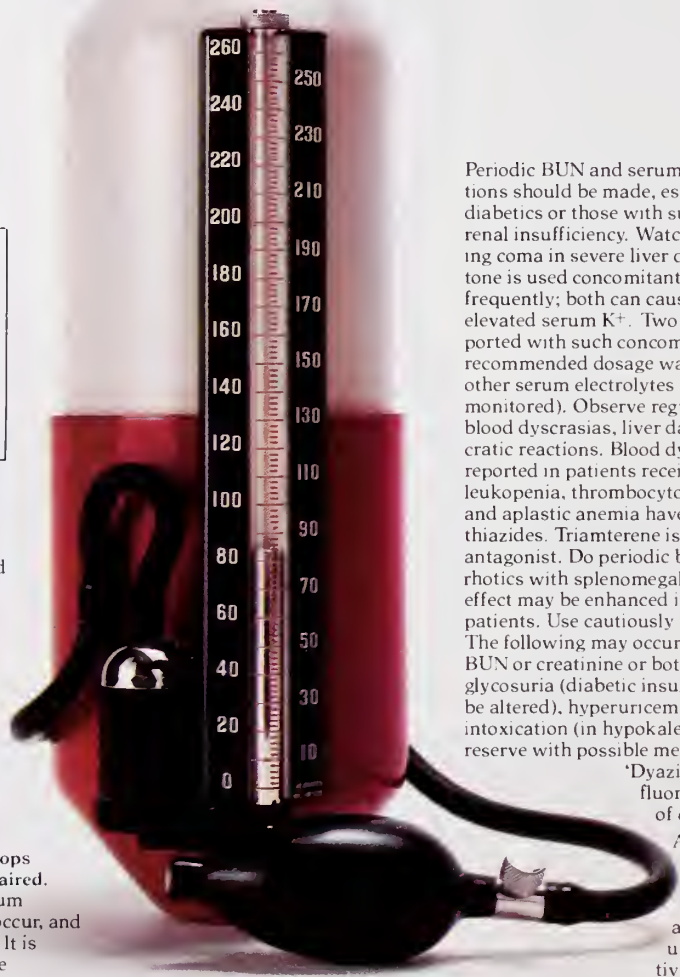
Adverse Reactions:

Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

SK&F CO., Carolina, P.R. 00630

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**FOR LONG-TERM CONTROL
OF HYPERTENSION*
SERUM K⁺ AND BUN SHOULD
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(SEE WARNINGS SECTION.)**

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This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

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Aerobacter
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Streptococcus
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Bacitracin

Staphylococcus
Corynebacterium
Streptococcus
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In vitro overlapping antibacterial action of Neosporin[®] Ointment (polymyxin B-bacitracin-neomycin).



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Neosporin[®] Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin[®] brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is

affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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struggle for wom-



Social Security Bill Is Signed, Gives Pensions to Aged, Job

Roosevelt Approves Message Intended to Benefit 30,000,000 Persons When States Adopt Cooperating Laws—He Calls the Measure 'Cornerstone' of His Economic Program

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution
is Sent to House, Where
Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today 94 to 0, and sent to

WASHINGTON, Aug. 15. The Social Security Bill, providing a broad program of unemployment insurance and old age pensions, and counted upon to benefit 20,000,000 persons, became law today when it was signed by President Roosevelt in the presence of those chiefly responsible for getting it through Congress.

Mr. Roosevelt called the bill "the cornerstone of my economic program which is being completed."

SIGNING the Draft Ends No

TRUMAN CLOSES UNITED NATIONS CONFERENCE WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great
Instrument of Peace,'
Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing
Ovation as Executive
Picture's Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA

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42nd and Dewey Avenue, Omaha 68105

Sexual Activity After Myocardial Infarction

— T. Kavanagh (Toronto Rehabilitation Centre, 345 Rumsey Rd, Toronto, Ontario, Canada) Can Med Assoc J 116:1250-1253 (June 4) 1977.

Questionnaires on sexual activity were completed by 161 patients attending an exercise-centered rehabilitation program an average of some three years after a myocardial infarction. In almost half the group, sexual activity was unchanged or increased compared with the period before the infarction. In the remainder it was reduced; this group included 29 men who had adopted a more passive sexual role and 26 who were having angina or ventricular premature beats during intercourse. Although the patients with diminished activity could not be distinguished by means of formal personality tests, questionnaires completed by their wives suggested that they were less willing to assume responsibility, had increased difficulty in adjusting to life at home and at work, and were more neurotic and depressed than those with normal or increased activity. Furthermore, those with decreased sexual activity had a poorer response to training in terms of attendance, final average jogging distance, and gains in physiologic status. Since the frequency of angina and ventricular premature beats was less during intercourse than during standard laboratory exercise, it was concluded that normal sexual relations carry no special risk for the average post-coronary patient.

Test Strip Meconium Screening for Cystic Fibrosis — W. T. Bruns et al (The Medical College of Wisconsin, Milwaukee, WI 53233) Am J Dis Child 131:71-73 (Jan) 1977.

The Boehringer-Mannheim Corporation (BMC) strip test is reliable in indicating an albumin content above 20 mg/gm of dried meconium. All infants born during one year in 14 Milwaukee area hospitals were tested. Of 16,224 newborns, two were diagnosed correctly as suffering from cystic fibrosis and two were missed. False-positive tests were obtained in 0.9% of infants (prematurity, melena, gastroschisis, and intrauterine infection). The strip test is, at present, the best available but not the perfect screening method for cystic fibrosis.

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Acute Venereal Arthritis — W. C. McCord et al (K. M. Nies, Harbor General Hosp, Torrance, CA 90502) Arch Intern Med 137: 858-862 (July) 1977.

Acute venereal arthritis, a syndrome of fever and inflammatory arthritis following recent sexual intercourse, is a frequently misdiagnosed arthritic presentation. Nearly half of 39 patients admitted with a diagnosis of acute gonococcal arthritis were subsequently recognized as having acute Reiter syndrome. A retrospective study of both diseases revealed differentiating features that, when prospectively applied to 21 consecutive patients, permitted a correct and prompt bedside diagnosis. Acute Reiter syndrome could be differentiated by characteristic mucocutaneous lesions, arthritis/tenosynovitis confined to lower extremities, massive recurrent knee effusions, low back pain, conjunctivitis, and genitourinary inflammation. Gonococcal arthritis could be differentiated by migratory arthralgias, high fevers, arthritis/tenosynovitis initially confined to upper extremities, topical cutaneous lesions, and dramatic defervescence to penicillin therapy. Laboratory data corroborated each diagnosis.

Quitting Marijuana — A. T. Pack et al (N. Q. Brill, Dept of Psychiatry, UCLA School of Medicine, 760 Westwood Plaza, Los Angeles 90024) Dis Nerv Syst 37:205-209 (April) 1976.

Marijuana quitters, continuing users, and never-users were compared. Never-users are found to be more conservative, traditional, and strongly identified with their parental role models. Continuing users are more unconventional, involved in risk-taking behavior, and lacking a stable identity. Quitters are intermediate in cultural attitudes and stance. They have the highest rate of determined ego identity, but have more often reported problems with intimacy and have more often sought help for emotional problems. Three types of quitters are identified: the experimenter whose use was a social accident, the ex-rebel who used marijuana during the postadolescent stage of psychosocial moratorium, and the emotionally fragile individual for whom marijuana was psychologically threatening.

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

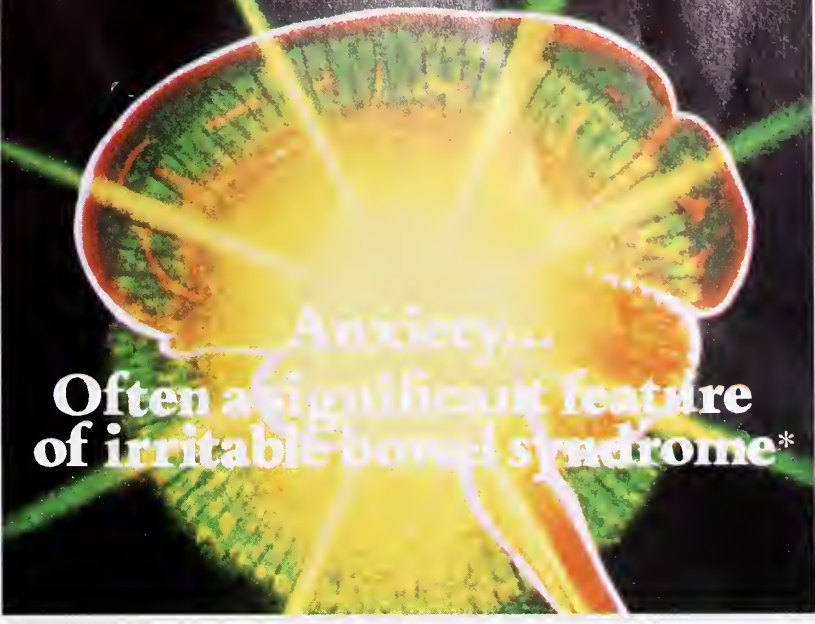
Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.





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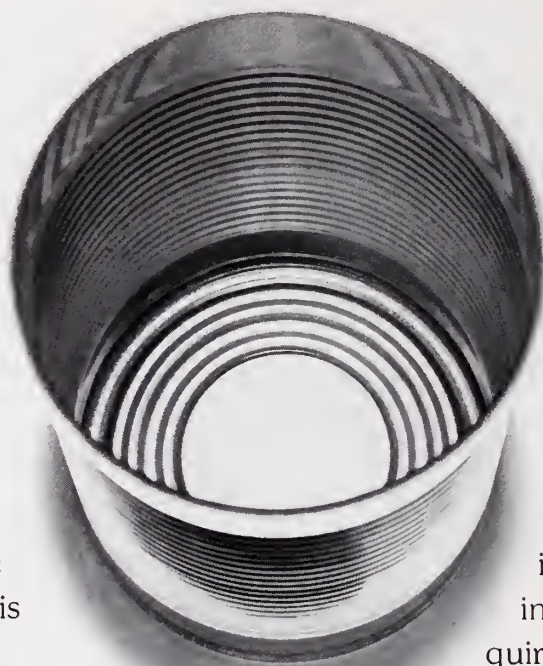
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5-Fluorouracil in Hepatocellular Carcinoma —

J. S. Link et al (Los Angeles County-University Medical Center, Los Angeles, CA 90033) Cancer 39:1936-1939 (May) 1977.

Twenty-one patients with biopsy-proven hepatocellular carcinoma received oral or intravenous 5-fluorouracil according to a randomized treatment schedule. Twenty-one patients were evaluable for response and toxicity. The two groups were comparable in distribution of pretreatment characteristics. There were no objective responses in either group. This study describes the largest group of patients with hepatocellular carcinoma treated with 5-fluorouracil. Toxicity, occurring in 46% of patients treated, was tolerable. In contrast to previous reports, the authors found that weekly 5-fluorouracil given orally or intravenously is not of great value in the treatment of hepatocellular carcinoma.

The Effect of Fetal Monitoring on the Incidence of Cesarean Section — M. J.

Hughey et al (Evanston Hosp, Evanston, IL 60201) Obstet Gynecol 49:513-518 (May) 1977.

To determine whether routine fetal monitoring inevitably increases the cesarean section rate, the authors studied the pertinent literature and analyzed the cesarean sections performed at Evanston Hospital during the last eight years. Many authors have found a slight to moderate increase in cesarean section rates, whereas others have found no change or a decrease. At Evanston Hospital, the primary cesarean section rate has increased from 2.6% in 1968-1969 to 6.9% in 1974-1975. Only 19.2% of this increase is due to increased fetal distress; the magnitude of the increase is due to changes in other factors, notably, breech deliveries (29.5% of the increase) and "dystocia" (60.2% of the increase). The incidence of cesarean section is controlled by several complex variables, only one of which is fetal monitoring. To describe the fetal monitors as the cause of increased cesarean section rate is to ignore other equally profound changes in obstetric technique and philosophy.

Tablets

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CONTRAINDICATIONS Hypersensitivity to oxycodone, aspirin, phenacetin or caffeine.

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Usage in children PERCODAN® should not be administered to children.

Salicylates should be used with caution in the presence of peptic ulcer or coagulation abnormalities.

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DRUG INTERACTIONS The CNS depressant effects of PERCODAN® may be additive with that of other CNS depressants. See WARNINGS.

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"Towards A Theology of Medical Science" Father Clifford Stevens

Father Clifford Stevens is a priest of the Archdiocese of Omaha and pastor of Saint Francis Church, Neligh, Nebraska. He is a graduate of Boys Town, attended Creighton University and completed his studies for the priesthood at Conception Seminary, Conception, Mo. Ordained in 1956, he served pastoral assignments in the Archdiocese of Omaha and in 1961 entered the Air Force Chaplaincy. During his years in the Air Force, he pioneered programs of adult theology and began extensive research and writing on the relationship between theology and science and technology. In addition to his assignment in the Air Force, Father Stevens has also served as the editor of theological publications and served briefly as the founder-director of the Theological Research Institute in Santo Fe. Father Stevens is the author of several books and his articles have been published by numerous periodicals.

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THE NEBRASKA MEDICAL JOURNAL

DOES PAIN HAVE QUALITY?

Musical sounds have pitch and volume, and they also differ in a thing called timbre, so that you can tell if you are listening to a violin or a flute. Light has intensity and color. Pain can be localised, and one pain can be more severe than another. We may know what brings it on, and how long it lasts, and even what makes it go away. But does it have quality?

Patients will describe pain as boring, we say lancinating, dull, aching, burning, toothache-like, or shooting. It has been characterized as lightning, fulgurant, and growing pain. But are these terms justified? Is it not possible that pain is pain, that one pain is like another, and that one pain differs from another only in intensity, and that a severe pain comes then to be spoken of as a sharp, darting pain? I have struck my thumb with a hammer, and I have known iritis and toothache, I have broken ribs and stubbed my toe; and what pains I have had were in different parts of me, but differed only in intensity, and of course some lasted longer than others, but I could not see any kind of quality.

Patients tell us these things, but we ask them to describe their hurts, and how do we put this to use in diagnosing? Is it not enough to say that the pain was in the left elbow, quite severe, and lasted five minutes, and did not come back? I am not a dolorologist, but I have hurt and I have observed, and pigs is pigs, and pain, I think, is pain.

—F.C.

OF MANY TESTS AND LAWYERS SUITS

It is possible that this may come to be known as the malpractice age of medicine. It has always been with us, but like Topsy, it is growing. But we read now of lawsuits on the one hand and of an undesirable multiplicity of tests on the other. I have been told of the complete waste involved in the routine and automatic ordering of x-rays where there was only hairline fracture, and of skull films

for every head injury; defensive medicine, it is called. And with it come rising costs.

These are not well thought out arguments. Patients who come to the emergency room are not selected at random; they are sicker than the general population composed of people who have been hurt, for some stay home. And if you do not order x-ray film of the skull where there is head injury, what then, when skull fracture is later found? And when there has been injury to an extremity, how will you know at night that only hairline fracture will be found a day or two later, and what cost will be saved if x-ray is to be taken later anyway?

We have multiplicity of tests now, but we have better medicine now, and while lawsuits drive health costs up, and while all testing does, too, there is this to think about. Much of this testing, and perhaps all of it, may be good medicine, and may be good for the patient. If a friend of mine came to the emergency room after having had a head injury, I should want a skull film; and I would treat others as though they were my friends.

—F.C.

DOCTORS TREATING DOCTORS

One of the fringe benefits of being a physician is knowing that when you are not well, another doctor, whom you may or may not know, will care for you, usually without delay, and more often than not, without pay. And we have always extended this courtesy to our colleagues.

Of course, things are different now; we have Medicare and Medicaid and Blue Cross and Blue Shield, so that your doctor-friend may get paid for treating you, which was formerly a courtesy, and which may still seem so to you.

But is a doctor-patient really a patient? Diagnosing in the doctors lounge is not practicing medicine, and see-me-anytime is no better. If you schedule an annual visit with your office patients, do you do it when

the patient is an M.D.? In short, does not the fact that you may know each other well, and that the patient knows medicine, too, interfere with the patient-doctor relationship between the two of you?

I have known doctors' wives who begged to be allowed to pay for their office visits, and then be treated like everybody else when they were sick, with the feeling that things would then be better if they were not known to be doctors' wives, and were not courtesy patients. I do not mean that we do not extend ourselves when we are not paid, in fact, we are often paid now; but I suggest that the very nature of our treating a fellow-physician can diminish the good that may result from the office or hospital visit.

—F.C.

GUARANTY, SECOND OPINION, AND MALPRACTICE

As our critics point out, the surgeon says to the patient, you must have an operation, and I will do it. We are told that we must not guarantee results, for this leads to lawsuits when cures are not provided; but is our telling the patient that the operation is advisable, and that it will therefore help, equivalent to a guarantee of a sort? I agree, it is not wise to tell the patient, I guarantee a cure, but I can not think that this is commonly done.

It is not common practice to say, I guarantee a cure, but criticizing us in this sense does not seem justified, for in our saying, you need this operation, do we not imply, this will help you? And how can this count against us? There may be a small difference between saying cure and saying help. But something to that effect *must be*

said. How can we tell the patient, I should like to take your gallbladder out, but the operation will do you no good?

As for the second opinion, can the situation where a doctor prescribes an operation and then does it himself, really be bettered? Where will the patient go for another opinion, to the surgeon's partner, or to his friend? And if the surgeon is competent, the other surgeons in the community are sure to be his friends. Or will the patient go to the government, to a government doctor, that is?

Second opinions are a good thing, I agree; but lawyers and dentists don't use them, not in my experience. I am not opposed to second opinions, I may be for them, but I have engaged surgeons, lawyers, and dentists without second opinions, and I emerged unscathed. And my surgeons said I needed the surgery, and they were right.

—F.C.

OF MAKING MANY ADVERBS THERE IS NO END

You cannot go on coining adverbs whenever you feel like it; as Ibsen says, people don't do such things.

Interestingly, we found, is easily edited to *we found*. One can always say later that it was interesting, but the whole idea of finding something interesting is best left to the reader. I have just run across *assumedly*, and that is what provoked this essay. *We assumed* is better, and the entire concept of assuming, like that of interesting, is unimportant, and in a scientific article, unscientific. If it is interesting, your colleagues and critics will think so, *hopefully*.

—F.C.

Umbilical Hernia in Children — Parental Feelings and Attitudes

IT is the purpose of this study to assess the parental feelings and attitudes of parents of children with umbilical hernia. A total 140 parents or guardians were interviewed and given a simplified questionnaire that was answered by 107 of them who were included in the study. Seventy-nine of the parents thought that the umbilical hernia is a harmless defect, and 73 of them were convinced that a spontaneous closure was forthcoming. Uncertainty as to the nature of the defect, prognosis and fear of complications had forced 74 of 107 parents interviewed to self doctoring the defect with adhesive tape, coins, patches, etc. Umbilical hernia was the cause of considerable family concern for 67 of parents and 35 of them

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expressed an apparent feeling of guilt for the anomaly. Surgical correction of the umbilical hernia, earlier than the currently in use timetable, was favored by 42 of 107 parents for apparently emotional, esthetic and intimate family reasons. It is recommended that the attending physician take into consideration these factors when caring for children with umbilical hernia and he is about to determine the proper time for surgical correction of the defect.

A Curious Case of Tinnitus

A 31-year-old white male has had tinnitus, in the left ear only, for years, as long as he can remember. He has no hearing problem. He remembers having his ear canals washed out, for cerumen, as a child. He is intelligent and honest, and apparently not neurotic. The tinnitus is constant. It is low-pitched, not a ringing or a whistle; it is aggravated by loud sounds.

He was recently in a dentist's office, where he underwent intraoral injection for anesthesia for treatment of a cracked tooth, on the right side. It seemed to me that he had undergone mandibular block. There was good anesthesia, and he experienced numbness from the angle of the jaw on the right side to the middle of the lower lip.

And his tinnitus went away.

FRANK COLE, M.D.
Lincoln, Nebraska

The tinnitus disappeared immediately after the block; when the anesthesia wore off, the tinnitus did not return. It came back 48 hours later, a little stronger than usual, and was noticed on waking. Three or four hours later, some 50 hours after the nerve block, its intensity came down to what it had been before the block and tooth repair, and it has persisted.

Perhaps it was the wide opening of the mouth; it may have been the dentist's manipulations; a left-sided block might have done as well. But it seems to me that a right-sided mandibular block cured a left-sided tinnitus, at least for a while.

Case Report: Compression of Transverse Colon, a Complication of Gastrectomy

Case Presentation

A 56 year old white male was admitted with 5 day history of diarrhea and epigastric pain. The initial impression was recurrent pancreatitis. He was emphysematous, hypertensive, and obese. He showed good progress for the first 3 days.

On the 4th hospital day, brisk upper GI bleeding took place with resultant shock. Exploratory laparotomy revealed multiple gastric ulcers actively bleeding. Vagotomy and antrectomy with antecolic gastrojejunostomy were carried out. Pancreas was diffusely edematous but not hemorrhagic or necrotic. He required volume respirator and intensive post-operative care.

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On the 4th day, there were signs of third space fluid loss. His abdomen gradually became distended. X-ray films of his abdomen showed dilated loops of small bowel and right side of colon (Fig 1). Long intestinal tube could not be advanced through gastrojejunostomy. The second film (Fig 2) showed obstruction at the transverse colon. It indicated the mesentery of jejunum



Fig. 1. Distended cecum, ascending colon and small bowel. No gas in descending colon or rectum.



Fig. 2. Tapering of mid-transverse colon. Surgical staples near-by.



Fig. 3. Complete decompression of cecum and ascending colon. Three hours after Figs. 1 and 2.

was pressing on the colon. The cecum measured to 13 cm. Immediate decompression was necessary. Rather than high-risk surgical intervention, we elected nonoperative physiotherapeutic trial. With close cardiorespiratory monitoring, he was placed on his right side, on his stomach, then on his left side, and finally on his back. This was repeated several hours apart. Massive evacuation of gas and liquid stool ensued. After the first sequential positional changes, his colon was completely decompressed (Fig 3).

His abdomen became soft and the abdominal girth decreased by 5 cm. Twenty-four hours later, cecal distension recurred. Roll-over exercise was again successful. From this point on, his recovery was uneventful. His GI tract was functioning normally by the 8th day.

This roll-over maneuver has also been very effective for paralytic ileus. Passage of a long intestinal tube is often facilitated by this maneuver.

Accuracy of Total Serum Enzymes and Myocardial Specific Isoenzymes — A Comparative Study

Synopsis

Comparison of total serum lactate dehydrogenase (LDH), glutamic oxaloacetic transaminase (SGOT), creatine phosphokinase (CPK), LDH₁:LDH₂ ration, and MB CPK* was studied in 83 patients presenting with chest pain. In patients with EKG evidence of acute transmural myocardial infarction, abnormally elevated total CPK, SGOT, and LDH was present in 26 of 30 patients (87%), 24 of 30 patients (80%) and 27 of 30 patients (90%) respectively. The LDH₁:LDH₂ ratio was reversed in 30 of 30 patients (100%) and MB CPK was present in 29 of 30 patients (97%). In patients with no EKG evidence of infarction abnormally elevated total CPK, SGOT, and LDH was present in 3 of 45 patients (7%), 5 of 45 patients (11%) and 5 of 45 patients (11%) respectively. In no patient was MB CPK present. Only 1 of 45 patients (2%) had reversal of the LDH₁:LDH₂ ratio. In all patients, MB CPK and the LDH₁:LDH₂ ratio combined manifest a sensitivity of 100%, and a specificity of 98%. Hence, MB CPK and determination of the LDH₁:LDH₂ are highly sensitive, specific and accurate and appear to be superior to total enzyme determination for the diagnosis of acute myocardial infarction.

*Myocardial specific CPK isoenzymes

THE use of diagnostic enzymology has increased exponentially since 1954 when Karmen, Wroblewski, La Due and their associates demonstrated that serum glutamic oxaloacetic transaminase (SGOT), and lactate dehydrogenase (LDH) activity increased following myocardial infarction.¹ The elevation of serum creatine phosphokinase (CPK) following acute myocardial infarction was first reported by Titus in 1960 and later confirmed by Hess and MacDonald.² However, comparative assessment has demonstrated a significant lack of sensitivity and specificity

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associated with these tests. For instance, total serum CPK appears to be the most sensitive of the conventional enzymes for the detection of myocardial necrosis, but is associated with approximately 15% false positive results.³ One reason for this lack of specificity is that increases in serum enzymes are seen in a variety of conditions other than acute myocardial necrosis including: severe congestive heart failure, hepatic disease, hemolytic disorders, surgical procedures, and intramuscular injections.⁴ More specific confirmation of acute myocardial infarction appears to be needed to extend diagnostic capabilities beyond the limitations of total serum enzyme evaluation.

This study evaluates the accuracy of tissue specific, electrophoretically separated, isoenzymes of both CPK and LDH in the detection of acute myocardial necrosis. They are shown to be highly sensitive, specific and accurate and appear to be superior to total enzyme determination.

METHODS AND MATERIALS

Eighty-three consecutive patients admitted to the Creighton Memorial St. Joseph Hospital Intensive Coronary Care Unit because of chest pain were studied. All patients underwent clinical, electrocardiographic, and laboratory evaluation which included: (1) serial twelve lead electrocardiograms, (2) total serum CPK and serum MB creatine

phosphokinase (CPK) determinations every 12 hours for 72 hours, (3) total LDH and SGOT determinations daily, and (4) LDH isoenzyme determinations on the 1st, 3rd, and 5th hospital day. If these were abnormal they were repeated every 3rd day until they returned to normal. Total serum CPK, SGOT, and LDH were estimated by standard techniques. LDH isoenzymes were electrophoretically separated on agarose film, stained with tetrazolium blue and their intensities quantified by a scanning fluorometer.⁵ The presence of MB CPK was determined by the electrophoresis of serum on agarose film according to the method of Elevitch.⁵ Total serum CPK, SGOT, and LDH levels elevated beyond the first standard deviation of this laboratory's control population were considered abnormal. All electrocardiograms were interpreted without the knowledge of the clinical course of serum enzyme studies. The electrocardiographic diagnostic criteria for transmural myocardial infarction were: (a) the appearance of new Q waves of 0.04 seconds duration or a 25% decrease in the height of the R wave in leads II, III, and AVF and/or (b) a new QS deflection or Q wave in the precordial leads. Subendocardial infarction was diagnosed in the presence of new, persistent flat or downward sloping ST segment depression of 2 mm or greater in the absence of significant Q waves. Other ST segment and T wave abnormalities, although recorded, were not considered evidence of myocardial necrosis.

Patients were divided into three groups: Group A consisted of 30 patients with electrocardiographic evidence of transmural infarction. Group B consisted of 45 patients without electrocardiographic evidence of acute myocardial infarction. Group C consisted of 8 patients with electrocardiographic evidence of subendocardial infarction.

RESULTS

In Group A: 29 of 30 patients (97%) had MB CPK present. The LDH₁:LDH₂ ratio was reversed in 30 of 30 patients (100%), Table I. Ninety-one percent of patients in whom MB CPK was present manifest this change on the first hospital day, and the change persisted for a mean duration of 48 hours. Reversal of the LDH₁:LDH₂ isoenzyme ratio occurred most commonly on the third hospital day (65%) of patients in Group A) and persisted for an average of 12 days. One patient who had reversal of the LDH₁:LDH₂ isoenzyme ratio did not have MB CPK present. However, he was admitted to the hospital 72 hours after the onset of chest pain. Abnormally elevated total enzymes were found in the following percentages of patients in Group A: CPK in 26 of 30 patients (87%), LDH in 27 of 30 patients (90%), SGOT in 24 of 30 patients (80%).

In Group B: No patient had MB CPK present. Only one patient of 45 (2%) had

TABLE I

Patients who manifested reversal of the LDH₁:LDH₂ ratio and/or the presence of MB CPK in their serum.

	Group A		Group B		Group C	
	Patients	%	Patients	%	Patients	%
MB CPK	29/30	97%	0/45	0	8/8	100
LDH ₁ :LDH ₂	30/30	100%	1/45	2	8/8	100

TABLE II

Patients who manifested elevated total serum enzymes

	Group A		Group B		Group C	
	Patients	%	Patients	%	Patients	%
CPK	26/30	87	3/45	7	7/8	88
SGOT	24/30	80	5/45	11	7/8	88
LDH	27/30	90	5/45	11	8/8	100

reversal of the LDH₁:LDH₂ ratio. Abnormally elevated total enzymes were found in the following percentages of Group B: CPK in 3 of 45 patients (7%), LDH in 5 of 45 patients (11%), and SGOT in 5 of 45 patients (11%) Table I.

In Group C: New persistent ST segment depression was associated with the presence of MB CPK and reversal of the LDH₁:LDH₂ ratio in all patients (8 of 8 patients). Both total CPK and SGOT were abnormally elevated in 7 of 8 patients (88%). Total LDH was abnormally elevated in 8 of 8 patients (100%).

DISCUSSION

It has previously been shown and is now accepted that determination of total CPK is a sensitive laboratory test for the routine diagnosis of acute myocardial infarction.^{6,7} Unfortunately, this test is associated with approximately 15% false positive results.³ Determination of total serum LDH has proven useful in the diagnosis of myocardial necrosis in patients who present for evaluation 72 hours following the onset of symptoms, but it also lacks total sensitivity. The results of this study confirm this, and show that determination of total SGOT is less sensitive than either CPK or LDH. Further, all three tests were associated with a relatively high incidence of false positive results (CPK 7%, LDH 11%, and SGOT 11%), i.e. they lack specificity. (Table II).

Techniques utilizing electrophoresis permit identification and quantification of tissue specific isoenzymes. Roberts has shown that only myocardium contains significant amounts of MB CPK.⁸ Previous studies had shown MB CPK activity in skeletal muscle. However, Smith demonstrated that these findings may be due to a confirmational change in the CPK molecule which alters its electrophoretic mobility and hence, accounts for MB CPK activity.⁹ Extracts of myocardium primarily contain LDH₁ isoenzyme, that LDH isoenzyme which migrates fastest toward the anode in an electrophoretic field. Acute myocardial infarction has been shown to be associated with reversal of the serum

LDH₁:LDH₂ ratio.¹⁰ Unfortunately, other pathologic states such as renal cortical necrosis and hemolytic anemias are also associated with this reversal but in the absence of these states it appears that reversal of LDH₁:LDH₂ ratio is a sensitive and specific indicator of myocardial necrosis. This study confirms this contention. Determination of both MB CPK and LDH isoenzymes correctly identified myocardial necrosis in 38 of 38 patients with electrocardiographic evidence of either transmural or subendocardial infarction (100% patients in Groups A and B). Only 1 patient of 45 (2%) who manifest no electrocardiographic evidence of myocardial infarction had an abnormal LDH₁:LDH₂ ratio. The MB CPK isoenzyme was not present in this patient. These values represent a sensitivity of 100% [TP/(TP+ FN)], and a specificity of 98% [TN/(FP+ TN)], and a predictive value of 97% [TP/(TP+ FP)]. Hence, determination of MB CPK and LDH isoenzymes is confirmed to be superior to determination of total enzymes in the evaluation of the presence or absence of myocardial infarction.^{10,11} Additionally, because the electrocardiogram was the standard by which the accuracy of isoenzymes was judged, determination of these enzymes is especially helpful in the evaluation of patients in whom the electrocardiogram is of little help as, for instance, in the presence of complete left bundle branch block or other severe interventricular conduction defect and in the presence of Wolff-Parkinson-White syndrome. In post operative states these isoenzymes are also extremely useful in the evaluation of the presence or absence of myocardial necrosis.^{12,13} Finally, however, it must be recognized that both the electrocardiogram¹⁴ and isoenzymes may fail to identify the presence of acute myocardial infarction even though they are the standard by which this diagnosis is presently made and, hence, we must continue efforts to find more sensitive tests to identify acute myocardial necrosis

References may be obtained on request.

Computerized Tomography of the Head — Part V

CEREBROVASCULAR DISEASE

Abstract

Computerized tomography (CT) of the head is a new, safe, noninvasive neuro-radiologic procedure that permits an evaluation of the stroke suspect patient under physiologic and in vivo conditions. Head CT permits the correct diagnosis of stroke to be made, the correct differentiation between occlusive cerebrovascular disease (infarction) and intracerebral hemorrhage, an evaluation of the extent of the disease, its location and appearance as well as the role of secondary neuropathologic processes such as edema, mass effect, and hydrocephalus ex vacuo.

Computerized tomography (CT) of the head, as has been previously described,^{1,2} is a new, safe, noninvasive neuroradiologic procedure for studying intracranial neuro-anatomy and evaluating intracranial neuropathology such as a cerebrovascular disease under physiologic, in vivo conditions.³⁻²¹ The clinical localization and diagnosis of stroke is not always clear-cut nor easily differentiated from that of a primary or secondary tumor, an abscess, or a subdural hematoma. Because of this, one finds that head CT plays an important role in correctly diagnosing a stroke, in showing the extent of the disease, its location and appearance and indeed, in differentiating a low density, dark, occlusive cerebrovascular lesion (infarction) from a high density, white, intracerebral hemorrhage.

Examples of cerebrovascular disease in which head CT played a major role in diagnosis and in demonstrating the extent of the disease, its localization and distribution, and the role of the secondary neuropathologic processes of edema, mass effect and hydrocephalus ex vacuo are illustrated below.

Figures 1 and 2 are examples of occlusive cerebrovascular disease or infarctions. Case 1 is a hypertensive 72 year old right handed

JOHN F. AITA, M.D.

white female with the sudden onset of a left hemiparesis. The head CT scan taken four days after the stroke shows a low density, dark, right frontotemporal region infarction that involves cortex and white matter and extends medially to the region of the striate nuclei and internal capsule with edema that compresses the anterior horn of the right lateral ventricle and deviates the ventricular system across the midline to the left.

Case 2 is a 19 year old hypertensive right handed black male who presented with the sudden onset of a left hemiparesis. The head CT scan taken almost four months later shows a small, low density, dark, right internal capsule infarction (lacune) with compensatory enlargement of the anterior horn of the right lateral ventricle (hydrocephalus ex vacuo).

Figures 3 and 4 represent examples of stroke secondary to intracerebral hemorrhage. Case 3 is a 70 year old hypertensive obese right handed black female in atrial fibrillation with the sudden onset of aphasia, right hemiparesis, and right visual field inattention. The head CT scan taken 13 days later shows a high density white hypertensive hemorrhage into the corona radiata and internal capsule of the left cerebral hemisphere with surrounding edema.

Case 4 was a 51 year old, hypertensive right handed white female with the sudden onset of a decreased level of consciousness and left hemiparesis. An emergency head CT scan taken approximately 7 hours later shows a large high density, white, hemorrhage into the basal ganglia and corona radiata of the right cerebral hemisphere extending into the right temporal and frontal lobes anteriorly

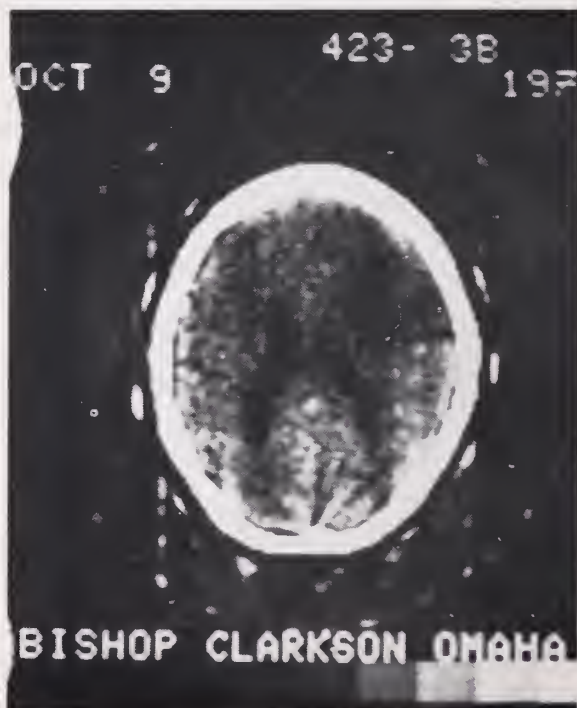
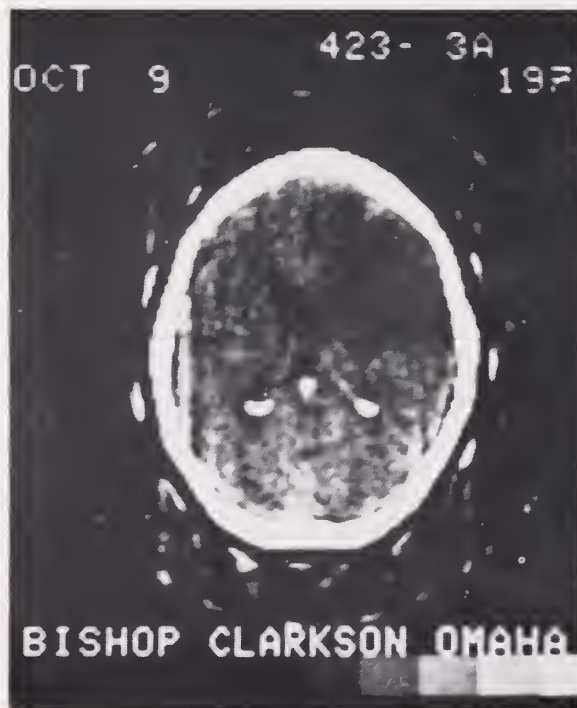
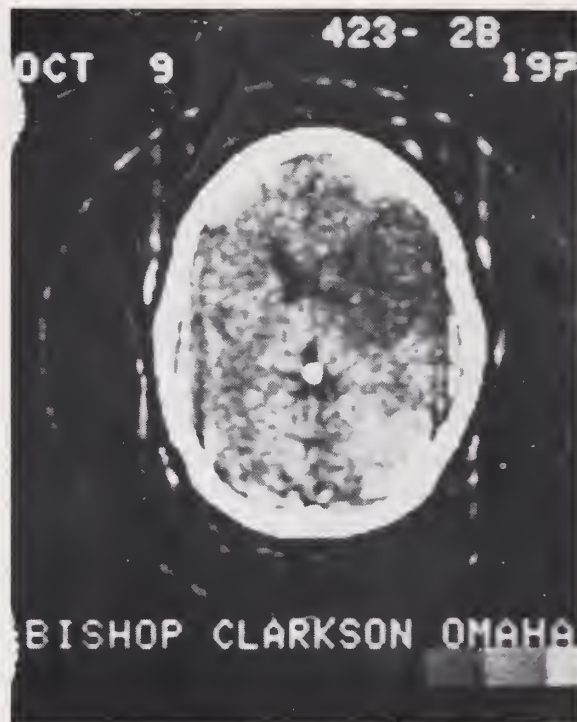
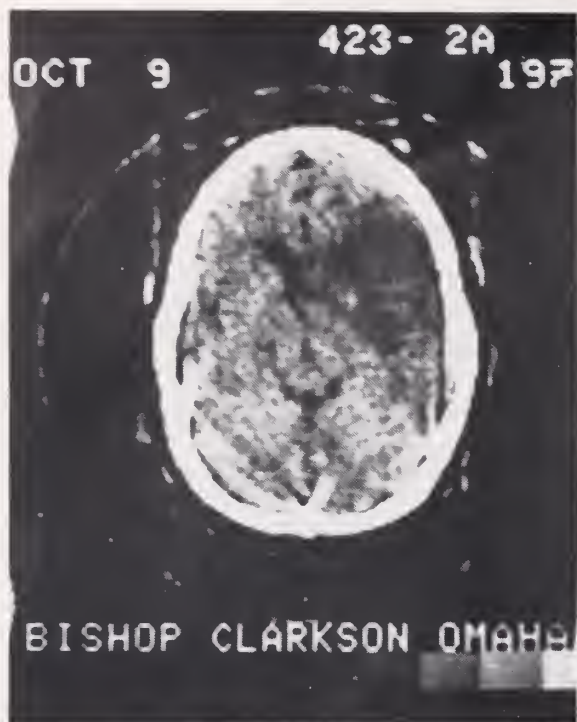


Figure 1

72 year old, hypertensive, right handed, white female with the sudden onset of a left hemiparesis. Head CT performed 4 days later shows a large, low density, dark, right frontotemporal region infarction that involves cortex and white matter, extends medially to the striate nuclei and internal capsule with edema that compresses the anterior horn of the right lateral ventricle, and deviates the ventricular system across the midline to the left.

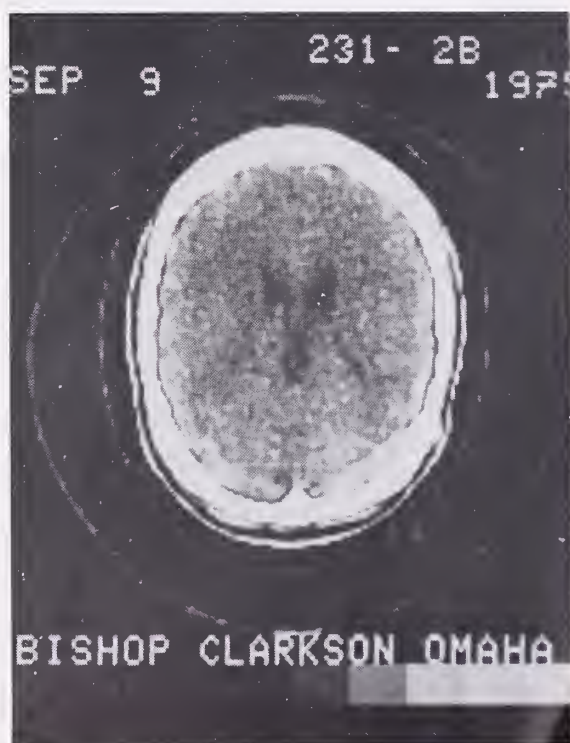
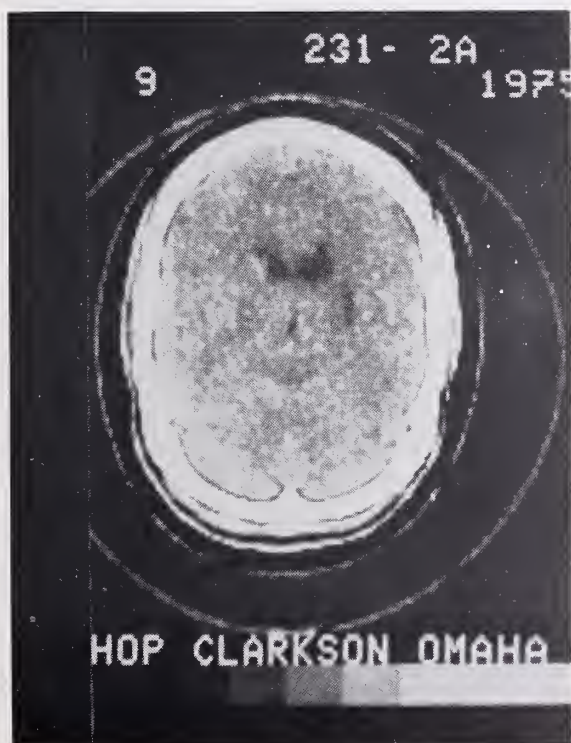
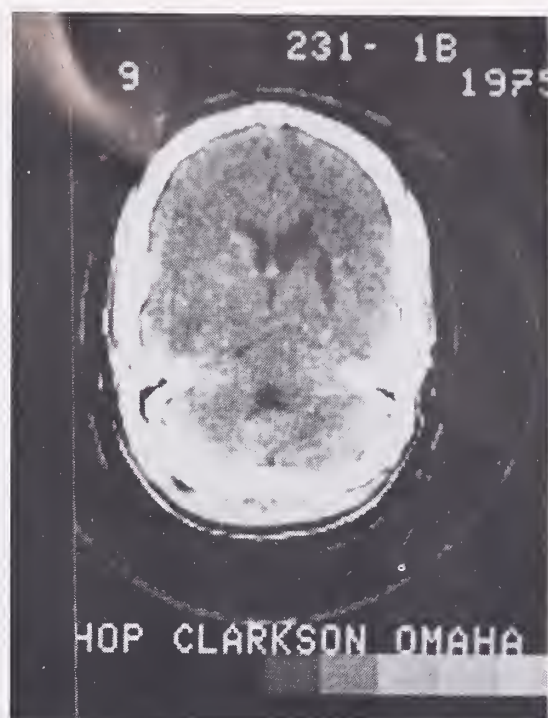
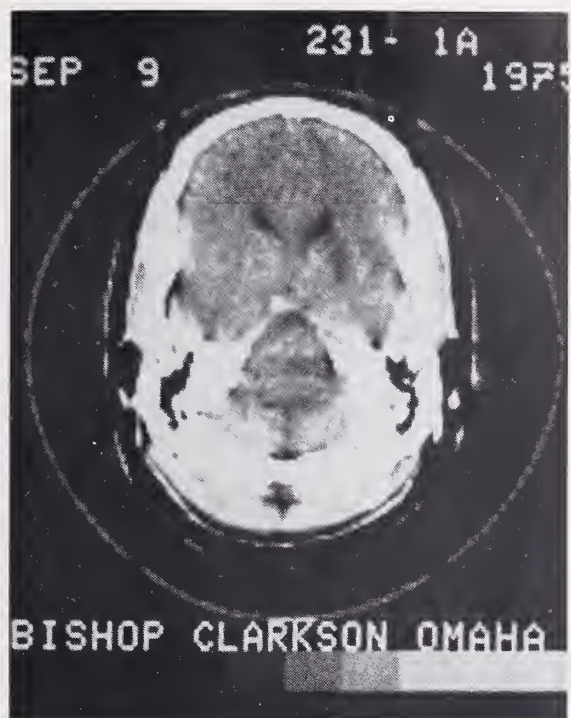


Figure 2

19 year old, hypertensive, right handed, black male with a sudden onset of a left hemiparesis. Head CT taken almost 4 months later shows a small, low density, dark, right internal capsule infarction [lacune] with compensatory enlargement of the anterior horn of the right lateral ventricle [hydrocephalus ex vacuo].

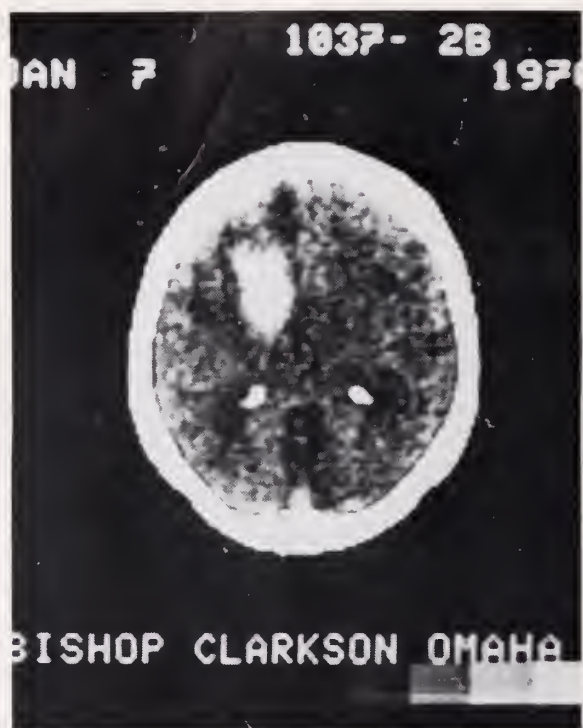
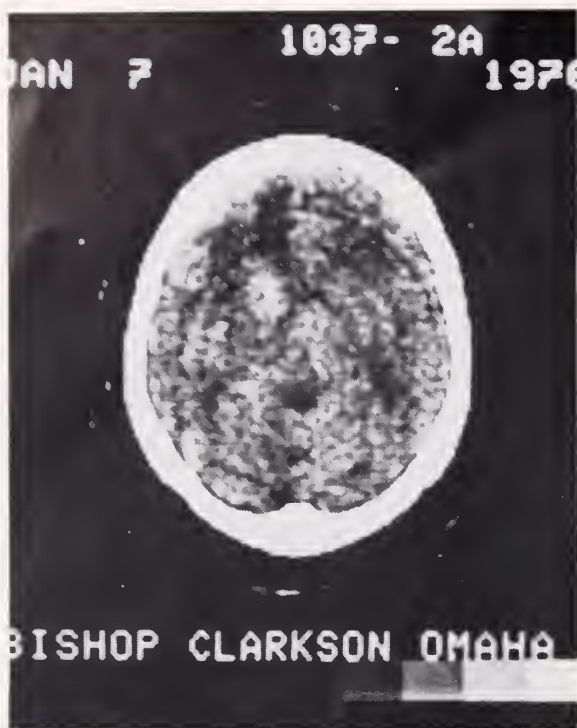
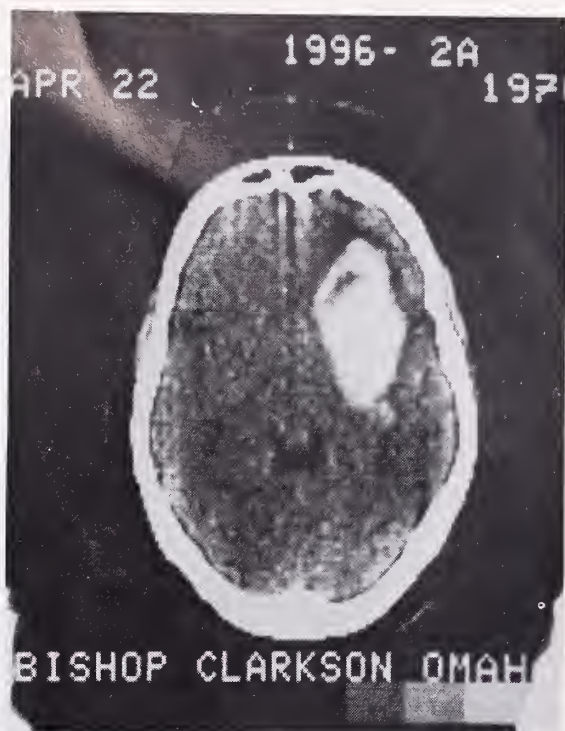


Figure 3

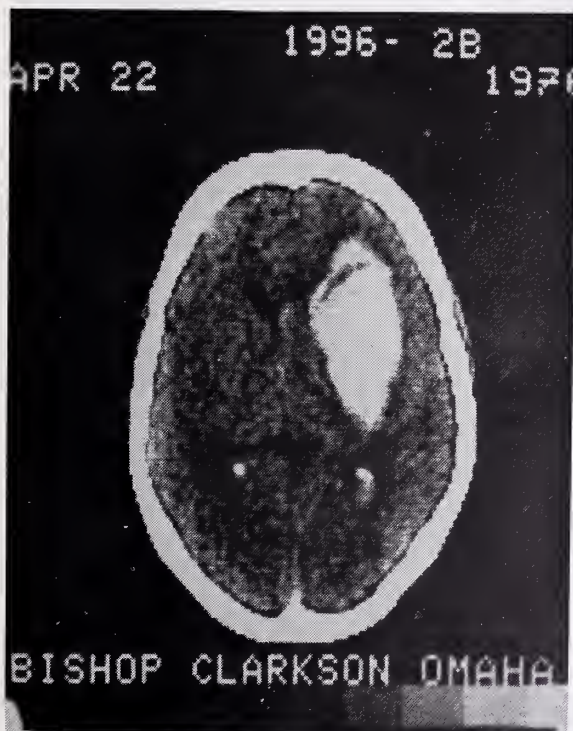
70 year old, hypertensive, right handed, black female in atrial fibrillation with the sudden onset of aphasia, a right hemiparesis and right visual field inattention. Head CT 13 days later shows a high density, white, hypertensive hemorrhage into the corona radiata and internal capsule of the left cerebral hemisphere with surrounding edema.



4-A



4-B



4-C



4-D

Figure 4

51 year old, hypertensive, right handed, white female with the sudden onset of a decreased level of consciousness and a left hemiparesis. Head CT 7 hours later reveals a large, high density, white, hypertensive hemorrhage into the basal ganglia and corona radiata of the right cerebral hemisphere extending into the right temporal and frontal lobes anteriorly with surrounding edema and mass effect with compression of the anterior horn of the right lateral ventricle and shift of the lateral ventricles to the left.

with surrounding edema and mass effect, as evidenced by the compression of the anterior horn of the right lateral ventricle and the

shift of the lateral ventricles across the midline to the left. The patient died 8 days later, and horizontal sections of the brain



Figure 5

Horizontal section of the brain in Case 4 at a level just inferior to that of Figure 4-B with the collapsed cavity of the intracranial hemorrhage within the right frontal lobe, edema and mass effect with a shift of structures across the midline to the left.

(Figures 5 & 6) at approximately the same angle as that of the head CT show good correlation with the CT of the head. Figure 5

which approximates a level just inferior to that of Figure 4-B and Figure 6 at approximately the level of Figure 4-C show the

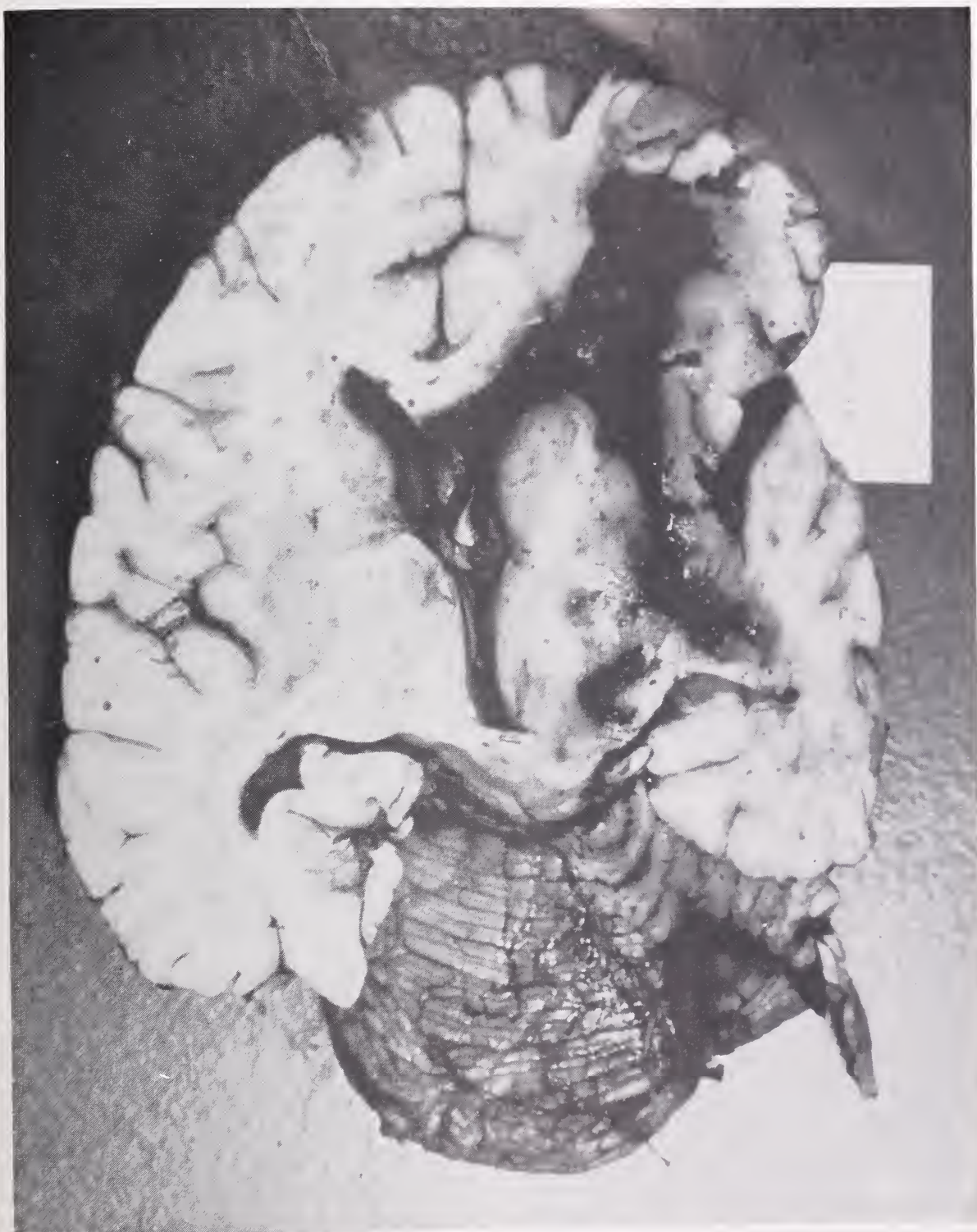


Figure 6

Horizontal section of the brain in Case 4 at approximately the level of Figure 4-C reveals the collapsed intracerebral hemorrhage cavity within the right frontotemporal lobes, impingement upon the anterior horn of the right lateral ventricle, edema and mass effect with midline structures shifted across the midline to the left.

collapsed cavity of the intracerebral hemorrhage within the right frontal and temporal lobes with impingement upon the anterior horn of the right lateral ventricle, as well as edema and mass effect with a shift of midline structures across the midline to the left.

DISCUSSION

Occlusive cerebrovascular disease, infarction, follows a vascular distribution with superficial lesions involving both gray and white matter and generally appears as a low density, dark, lesion on head CT. Acutely the appearance is nonhomogeneous, patchy, and blends in with the surrounding edema as in Case 1, and usually is first seen by head CT after the second day although one could expect that the borders would first become manifest on head CT at 12 to 24 hours.^{12, 19} However, large areas of infarction have been reported on head CT at about 24 hours and as early as 8 hours in one case.^{13, 15, 19} At approximately 14 days after the infarction one may see evidence of contrast enhancement around the infarction with head CT which is felt to represent the neovascularization seen neuropathologically in infarctions at this age. Still later as the infarction is cleaned out by phagocytic cells and becomes a cystic cavity by approximately three months, the head CT appearance becomes more homogeneous and in place of the edema, hydrocephalus ex vacuo may be seen, as in Case 2.

The appearance, extent and distribution of and anatomic location of a high density, white, intracranial hemorrhage is readily apparent on CT of the head as is the surrounding, dark, edema and evidence of mass effect. Some authors have attempted to differentiate a primary intracerebral hemorrhage from an intracerebral hemorrhage caused by a ruptured aneurysm, and to predict the site of the aneurysmal rupture on the basis of location and appearance of the hemorrhage.²⁰ The value of rapid and accurate localization of an intracranial hemorrhage is illustrated by a recent case of a posterior fossa hemorrhage where one needed to differentiate between an intracerebellar hemorrhage which is treatable surgically and an intrapontine hemorrhage which is not.²¹ It appears that initially, with head CT, an

intracerebral hemorrhage appears dense, white, and that over the next three to six months it becomes a low density, dark, lesion which was originally felt to represent complete resorption and disappearance of the clot, but has been found to represent only a change in the composition of the clot as on pathologic sectioning of the brain residual clots without evidence of recent bleeding have been found.⁸

In the 4 cases presented above, the clinical diagnosis of cerebrovascular disease was made clinically, but it was not always readily apparent whether the lesion was an infarction or a hemorrhage (eg Case 3), nor could the exact origin and location of the hemorrhage be localized clinically (eg Case 4). Head CT revealed the nature of the cerebrovascular disease, differentiated it from other neuropathologic lesions as well as differentiating infarction from hemorrhage, and demonstrated the position, shape, and extent of the lesion in addition to the secondary neuropathologic processes — all factors which help determine further clinical evaluation, treatment and prognosis.

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Down Memory Lane

I do not believe that a clinical entity has as yet been evolved which can with any assurance separate the symptoms produced by a chronically dilated duodenum, from those of gastro-duodenal ulcer or infections of the gallbladder, unless it be by the x-ray.

The advent of insulin has in no way displaced the dietetic control of diabetes, in fact it has re-emphasized the importance of diet.

The sacredness of the relation between doctor and patient is today oftener on the lips of the physician than of the patient.

If organized medicine were to take in imagination a total responsibility for the nation's health it would be assuming control of a public utility involving the expenditure of well over a billion dollars a year.

No one will seriously question the fact that the poor should have proper medical care and treatment. But this is an obligation that should fall squarely on the shoulders of the entire community, not only to the doctors.

I notice that we still have a few, I mean a very few, physicians that tell the mothers to buy a package of patent infant food and to follow the directions on the can or bottle.

In agricultural Nebraska, the surgeon must at times have a crop failure. Surgeons sometimes fix an amount as the minimum fee and, if the patient cannot pay this, there is no charge.

The contract has been let for the building of a Lutheran Hospital at Fremont. The building is to be of brick and four stories in height.

The dramatic element in surgery, the rapid transition from prostration to recovery, cannot but be impressive, while the slower and less striking methods of the internist often leave the slumbering question whether that patient has really been cured or has merely recovered, to awake to indignation under the shock of a substantial bill.

Nebraska State Medical Journal
February, 1928

President's Page

WE CAN'T DO IT

Why this pessimistic attitude? Only to point out that we, the Nebraska Medical Association, can't do a lot of things that you the physicians want us to do. I have the feeling that some think we fail to do things because we don't want to do them but our hands are tied. I want to mention a few of the things we can't do. One is to elect your political idol whether he be good, bad, or indifferent. So, don't ask us to elect your favorite politician.

We can't give money to your favorite politician. We are not permitted to do this so don't criticize us if your favorite politician needs money for his campaign and we don't send it to him.

We can't get involved in political races and speak out for this or that candidate, so don't expect the Nebraska Medical Association to do this for you.

But don't lose faith, there are things *you* can do to accomplish these ends, namely join the organizations that are politically permitted to do the above, namely, join politically oriented groups like the Nebraska Medical Political Action Committee (Neb Med PAC) and the National American Medical Political Action Committee (AM PAC). Support them to the point that your dollars and political influence will allow.

So much for what the Nebraska Medical Association can't do, let me reiterate a few of the things we can do.

Consider the politicians you have already elected. These we can influence if you give us direction. We need your input and expressed opinion and if unified we can save the politician much research in ferreting out his constituent's opinion. This also goes for any impending legislation affecting us.

We have already had much influence on professional liability insurance but we need your continued support and input. National health insurance looms in the horizon for which we need your continued input. Maybe the input will be fruitless but at least we can say we tried.



Much pressure is being put upon us in regard to Medicare and Medicaid Fraud and Abuse and the cost of health care in general. We can fight these issues as long as you help us.

The Federal Trade Commission is constantly attacking organized medicine and with your support we will continue to fight back.

Much has been gained recently in the Hospital-Physician relations and with continued cooperation we hope to have great impact on hospital regulations and rules as well as in the field of Cost Containment.

Our effectiveness in representing the profession in these and other important issues hinges upon the unity within the profession. Yes, there are some things the Nebraska Medical Association can't do but consider the great number of things we can do if you continue to be a member and convince others to join the Nebraska Medical Association.

Arnold W. Lempka, M.D.



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The Auxiliary

OPERATION COMPASSION

One area chosen for special emphasis by the Family and Community Health Chairman this year is entitled "Operation Compassion." This involves any project, large or small which will improve the quality of life of the homebound or the senior citizens in our communities.

The elderly are no longer the forgotten generation in America. Much legislation has been passed to provide services for those in need. Many private and public organizations have programs which help make the life of the senior citizen as pleasant and productive as possible. Much still remains to be done. This is where we can become involved.

With the needs of your community in mind, would it be possible to provide any of these services in your community?

Escort Service — Transportation would be provided for grocery and personal shopping, for medical and dental visits, social and church activities, and to cultural events such as concerts.

Telephone Reassurance — Persons receiving reassurance assistance are called (or call in) at a predetermined time each day. This provides an opportunity for alleviating some of the fears of living alone as well as an opportunity to visit with someone each day. If an emergency arises, a specified neighbor or emergency service can be contacted.

Repairs on Wheels — This service would be provided to those unable to do their own repairs or unable to pay to have this type work done. This project would require more initial organization and the assistance of male volunteers. Utilizing retired persons would benefit both the recipient and the supplier of this service.

Nutrition — In many instances, poor nutrition among the elderly is due to a feeling of isolation and loneliness which makes preparation of a meal to be eaten alone seem hardly worthwhile. Many times well balanced meals are eliminated and frequent snacks are substituted.

Projects which might involve Auxiliary members could vary from a one to one relationship in planning nutritional menus to teaching a widower cooking skills. Auxiliaries with larger memberships might assist with Meals-On-Wheels or a Senior Diner Program (or a similar congregate dining program.)

The second area of emphasis for the year will be on Television Viewing. The arguments against excessive violence are well accepted now, but we can still express our opinions to the television station managers and networks regarding the type of programming available. Action for Children's Television is now looking at the commercials which are shown during children's programs: candy ads, breakfast cereals which resemble chocolate chip cookies, and those implying the "chocolatey" cereals provide a balanced breakfast. Many commercials are counter-productive to the development of children's language skills — is there really a candy bar which is "thickerer?"

There are excellent programs available for children. The three major networks sponsor weekly "Afterschool Specials." The Public Broadcasting System is expanding its programming in this area.

Only a small percentage of parents (5-15%) actually prohibit their children from viewing programs known to contain violent material. Will you please take the time to monitor what your children are viewing? Then take the time to write your views to the networks or the advertisers.

Mrs. Palmer Johnson
Family and Community Health Chairman

Picture Gallery

NEBRASKA HIGH SCHOOL TEAM PHYSICIANS SEMINAR
SATURDAY, NOVEMBER 12, 1977



Patrick E. Clare, M.D., Chairman of the NMA Subcommittee on Athletic Injuries, presiding.



Patrick E. Clare, M.D.



Nebraska High School Team Physicians Seminar.



Nebraska High School Team Physicians Seminar



Nebraska High School Team Physicians Seminar.

Simple
drops of water
help make
COLACE[®] the
most widely used
stool softener.

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COLACE works by stool-softening action alone, free from laxative stimulation. Simply by letting natural intestinal water permeate stools, COLACE helps to eliminate the hard, dry stools common to constipation.

COLACE works to prevent pain and straining at stool with minimum chance of griping or cramps, particularly in patients with delicate anorectal disorders. COLACE is safe and non-habit forming in short- or long-term therapy. COLACE—the simple water way to ease constipation from infancy to old age. Capsules, syrup or liquid.

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PHARMACEUTICAL DIVISION

COMPATIBILITY



Eastern Tiger Swallowtail Butterfly
(*Papilio glaucus*)

Does it influence your choice of a peripheral/cerebral vasodilator*?

Vasodilan—compatible with coexisting diseases (e.g., glaucoma, diabetes)

Vasodilan has not been reported to affect the course of coexisting disease; it has not been reported to affect blood sugar levels or to raise intraocular pressure.

Vasodilan—compatible with concomitant therapy

Vasodilan has not been reported to affect the treatment of coexisting disease; it is compatible with such drugs as hypoglycemics and miotics.

Vasodilan—compatible with your total regimen for vascular insufficiency

Vasodilan can be a valuable adjunct in planning a total therapeutic program for vascular insufficiency.

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.

Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836



VASODILAN[®] 20-mg tablets

(ISOXSUPRINE HCl)

20 mg q.i.d. recommended dosage

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PHARMACEUTICAL DIVISION

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This asthmatic isn't worried about his next breath...

**he's active
he's effectively
maintained on**

QUIBRON[®]

Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

- high theophylline for effective around-the-clock therapy
- 100% free theophylline
- individualized theophylline dosage schedule

Indications: For the symptomatic treatment of bronchospastic conditions such as bronchial asthma, asthmatic bronchitis, chronic bronchitis, and pulmonary emphysema.

Dosage: Initial: Adults: 1-2 capsules or 1-2 tablespoonfuls elixir every 6-8 hours, children 8-12: 1 tablespoonful or one capsule every 6-8 hours and children under 8: 3 to 5 mg theophylline/kg body weight every 6-8 hours. Theophylline dosage may be cautiously increased to 2000 mg/24 hr in adults or 7 mg/kg in children; monitoring of serum theophylline levels at higher dosages is recommended.

Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea and vomiting. The frequency of adverse reactions is related to the serum theophylline level and are not usually a problem at serum theophylline levels below 20 µg/ml.

How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

Mead Johnson

PHARMACEUTICAL DIVISION

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Picture Gallery

NEBRASKA HIGH SCHOOL TEAM PHYSICIANS SEMINAR SATURDAY, NOVEMBER 12, 1977



Pat Dyer, Regional Promotion Director, Southern Athletic / Bike - Plano, Texas; Former Head Trainer - Georgia Tech.



Pat Dyer.



Bobby Gunn, Regional Promotion Director, Rawlings Sporting Goods Company - St. Louis, Missouri; Former Head Trainer - Washington Redskins and Houston Oilers; Past President - National Athletic Trainers Association.



Bobby Gunn.

Our Medical Schools

ANNUAL PEDIATRIC PROGRAM — SKIN AND BONE; February 3-4, 1978; Sponsored by Creighton University School of Medicine held in Omaha, Nebraska.

Credit: As an organization accredited for continuing medical education, the CREIGHTON UNIVERSITY SCHOOL OF MEDICINE certifies that this continuing medical education offering meets the criteria for 10

credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association, provided it is used and completed as designed.

Program is acceptable for 9 prescribed hours by the AAFP. Fee: \$75. Designed for: Pediatricians, family physicians. Write to: Continuing Medical Education, Creighton University School of Medicine, Omaha, NE 68178.

Between Cases

Department Of Definitions.

A doctor is someone who still has his tonsils and adenoids and appendix.

Anon.

See?

Somebody important, sounds like. Editor or something.

Lockridge, R: A streak of light.

From An Old Set of Rules.

Ambulant patient will not leave his bed without first making the bed up.

Words I Can Do Without.

Logistics, acerbic, counterfactual, reconceptualization, interrelationships.

Section On Pathology.

The valves in the aorta are scored.

Leslie Miner: Psychic.

Heard On TV.

That was unique and strange.

Syndromes You May Have Missed.

Counter-disaster syndrome, tired arm syndrome.

Way To Go.

She died a natural death.

Beginnings Of Answers To Difficult Questions.

I know of no study that . . .

History & Physical.

Had spastic paresis over the extremities and wears external catheter for this.

Diagnosis.

Plantar wart on foot.

The Lab Report.

Grand-negative.

The Conclusion.

I have no objective end at present.

The Diagnosis.

Migraine headaches.

On Christmas goodies.

Christmas calories.

I Give Up.

He was treated and conservatively managed at that time and bracing in such to this mannerism.

The Patient.

High pretension.

Postgraduate Gems.

If everything seems to be going well, you have overlooked something.

—F.C.

Nebraska M. J.

In Memoriam

*By medicine life may be prolong'd
yet death*

Will seize the doctor too.

—Shakespeare

DR. MAURICE J. AYRES

Doctor Maurice J. Ayres died on October 4, 1977, at the age of sixty-six. Doctor Ayres was born in Syracuse on May 7, 1911.

He was graduated from the University of Nebraska College of Medicine in 1940. He practiced medicine in Lexington for two years prior to opening a practice in Gothenburg in 1947.

He is survived by his wife, Irene; one son, Dr. Robert Ayres of Gothenburg; one daughter, Mrs. Denny (Nancy) Stara of Lincoln and one sister, Mrs. Kenneth (Helen) Johnson of Sunland, Calif.

DR. CARL C. BARR

Doctor Carl C. Barr died on December 9, 1977, at the age of sixty-two. He was born in Tilden on June 21, 1915.

He was graduated from the University of Nebraska College of Medicine in 1941. After a short practice in California, Doctor Barr returned to Tilden to practice medicine. Ill health forced Doctor Barr to retire in 1975.

He is survived by his wife, Ina Marie; one son, Dr. William C. of Tilden; one daughter, Mrs. Carl (Barbara) Friedrich of Idaho Falls, Idaho; one brother, Dr. Robert E. Barr of Tilden; two sisters, Dorothy Johnston and Gwyn Osborn, both of Yuma, Ariz.; five grandchildren.

DR. SAMUEL D. COWAN

Doctor Samuel D. Cowan died on November 26, 1977, at the age of eighty-seven. He was born in Halleck, Missouri, on July 17, 1890.

He was graduated from Ensworth Medical College in 1911. Following an ENT internship, he opened a practice in Falls City in 1914 where, excluding military service, he practiced until his retirement in 1974.

Doctor Cowan was recognized by the Nebraska Medical Association as a fifty-year practitioner in 1961.

He is survived by a daughter, Mrs. Dan F. (Peggy) Chaney, Seattle, Wash.; the son, Dr. S. D. Cowan, Jr., Falls City; 10 grandchildren, and four great-grandchildren.

DR. DWIGHT O. HUGHES

Doctor Dwight O. Hughes died on December 7, 1977, at the age of seventy-eight. He was born in Davenport on April 26, 1899.

He was graduated from the University of Nebraska College of Medicine in 1924. Doctor Hughes had practiced medicine in Fairbury since 1925, retiring in 1975.

Doctor Hughes was recognized by the Nebraska Medical Association as a fifty-year practitioner in 1974.

He is survived by his daughters, Mrs. Lawrence DeBusk of Los Altos, Calif., and Mrs. Richard Ray of Woodland Hills, Calif.; brothers, Leon of Kearney and Guy of Oakley, Kan.; sister, Mrs. Francis Michaelis of Lincoln; 11 grandchildren and one great grandchild.

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Books



Clinical cardiology; by Maurice Sokolow, M.D. and Malcolm B. McIlroy, M.D.; 659 pages; limp cover \$16.00; published December, 1977 by Lange Medical Publications, Los Altos, California.

This appears to be a first edition of an excellent book which is to be published in a revised edition every two years. There are 23 chapters and a good three-column index. The text is studded with figures, and there are

references at the end of each chapter. The print is good.

The book is of course up-to-date. The authors are professors of medicine at the University of California, San Francisco. I could think of nothing the authors have omitted, and I found the reading easy and the book informative; and I recommend it.

—F.C.

Coming Meetings

NEBRASKA MEDICAL ASSOCIATION
ANNUAL SESSION — April 30 - May 3,
1978, Lincoln Hilton Hotel, Lincoln, Ne-
braska.

THE FIRST INTERNATIONAL SYMPOSI-
UM OF THE INTERNATIONAL COL-
LEGE OF PEDIATRICS — June 18-22,
1978, Finlandia Hall, Helsinki, Finland.
Plenary Sessions, Symposia, Round-table
discussions, Free papers. George D.

Maragos, M.D., M.Sc., Associate Professor
of Pediatrics, Creighton University Medical
School, Omaha, Nebraska, 68108, USA.

AMERICAN MEDICAL ASSOCIATION —
Annual Convention, June 17-22, 1978, St.
Louis, Missouri.

NEBRASKA MEDICAL ASSOCIATION
FALL SESSION — September 21-23, 1978,
Lincoln Hilton Hotel, Lincoln, Nebraska.

Physicians' Classified

Advertisements in this column are run at a rate of twenty cents per word with a minimum of \$10.00 per insertion. Copy must be received by the fifth of the month preceding date of publication and should not exceed 50 words. Each advertisement will be taken out following its first appearance unless otherwise instructed. Where numbers follow advertisements, replies should be addressed in care of The Nebraska Medical Journal, 1902 First National Bank Building, Lincoln, Nebraska 68508.

FAMILY PHYSICIAN — Opportunity to join six-man group in beautiful Northwest Iowa. New clinic building of 10,000 square feet is located next door to 88-bed county hospital. Unusually progressive community of 10,000 offers 3,000 acre lake, 85 acres of parks and recreation, local liberal arts college, and many family interest features. Generous salary with incentive, malpractice insurance, liberal vacation and seminar time, partnership in one year. Contact: D. A. Pritchard, Administrator, Buena Vista Clinic, 620 Northwestern Drive, Storm Lake, Iowa 50588.

STAFF PHYSICIAN — General practitioner to perform general examination, care, and treatment of patients or staff at state psychiatric hospital. Forty-hour week with rotating on-call duty. Starting salary of \$29,892 increasing to \$31,380 in six months. Excellent benefits. Contact: H. D. Herrick, M.D., Superintendent, Norfolk Regional Center, Box 1209, Norfolk, Nebraska 68701. Call Collect: 402-371-4343.

EMERGENCY ROOM PHYSICIAN — Immediate opening for qualified physician. New hospi-

tal; new modern E.R. Dept. Good working conditions with all supportive services. Four - twelve-hour days per week. No weekends. Contact: Administrator, Lutheran Memorial Hospital, 2116 West Faidley, Grand Island, NE 68801 (308) 382-3890.

FOR LEASE — Modern office space in medical building — ideal for general practitioner or specialist — can accommodate two doctors easily — 2,000 sq. ft. — interior completely finished — previous occupant retired — lower level occupied by Dentist — ample parking — heavily populated area, centrally located to all major hospitals. Write: L. J. Kelley, DDS, 2821 North 56th Street, Omaha, Nebraska 68104.

PSYCHIATRIC RESIDENCY: Vacancies for (PG2 through PG4 only) positions for July 1, 1978, for those who have a regular Iowa license or can obtain one by reciprocity or via FLEX. Prepare for career in private practice, community clinics or hospital-based psychiatry. Emphasis on close supervision of intensive individual and group psychotherapy, OPD, Children's Unit, Adolescent Unit. Neurology affiliation with University of Iowa. The stipends are: 1st year, \$22,360; 2nd year, \$23,478; 3rd year, \$24,674. Intensity and diversity of training program appreciated best by personal visit. T. B. McManus, M.D., Superintendent, Mental Health Institute, Cherokee, Iowa 51012. Equal Opportunity Employer. Call Collect 712-225-2594.

WashingtonNotes

The Congress.

The first session of the 95th Congress has adjourned and in its wake leaves no major new health legislation. Touted as the most liberal Congress of recent years its actions on balance with respect to health legislation proved to be more conservative than liberal.

And both Congress and the Carter White House have left the question of national health insurance (NHI) legislation next year very much up in the air. Health, Education and Welfare Secretary Joseph Califano has announced Administration proposed NHI legislation may not be ready until 1979.

Shortly thereafter, however, President Carter reassured United Automobile Workers Union leaders and Senator Edward Kennedy (D-Mass.) that a full NHI legislative proposal would be forthcoming in 1978, but reaffirmed his intent to first send Congress a statement of principles, followed shortly by a bill.

Inflation.

In an attempt to do something about that spiraling health care inflation noted by Rep. Rostenkowski three major health organizations have agreed on a sweeping national program to curb hospital rate increases through a private sector review system aimed at encouraging hospitals to seek efficiencies and to spotlight institutions that fall down on the job.

Responding to a challenge from Congress for a voluntary alternative to the Administration's proposed Hospital Cost Containment Act for federal controls, the National Steering Committee has issued a 15-point program featuring a goal of a two percent reduction a year in the rate of increase in hospital costs.

The steering committee was formed by the AMA, the American Hospital Association (AHA) and the Federation of American Hospitals (FAH). In addition to officials of

these organizations, members of the committee include officials of the Health Insurance Association of America, the Health Industry Manufacturers Association, the Blue Cross Association, consumer consultant Virginia Knauer, and the U.S. Chamber of Commerce.

Here is the tentative 15-point program agreed to by the National Steering Committee:

1. Creation by state hospital and medical organizations of state level voluntary cost containment committees to develop special action programs for their states.

2. Immediate reassessment by all institutions of planned budget and charge adjustments to determine what can be done to shave costs in the short run consistent with sound medical practice.

3. Make the overall national goal a two percent annual drop in the rate of expenditure hikes for the next two years.

4. Set up guidelines for consideration by hospitals and state committees to identify hospitals where special efforts need to be made to cut costs. Under these guidelines, the top 15 percent of hospitals projecting the highest increases would be reviewed first, as well as others showing a higher than average rise in expenditures.

5. As a national goal reduce significantly the rate of the new capital investment by hospitals over the next two years. Also as a national goal — no net increase in the national total of hospital beds with certain exceptions.

6. Request that all hospital medical staffs consider ways to further tightened utilization review — consistent with sound medical practice.

7. Study and development by state committees of programs to improve productivity in hospitals by two percent a year.

8. Accelerate current trends to improve the health delivery system through multi-hospital systems, shared services, health

maintenance organizations and single and multi-specialty medical groups.

9. Notify all concerned of the national program and urge widest support and co-operation.

10. Provision of technical assistance programs by the AMA. The AHA and the FAH to assist the state committees and hospitals in carrying out the program.

11. Urge hospital suppliers to support the program and exercise restraint in pricing.

12. Establish a subcommittee on public education to actively involve everyone in the program and to explain it to the public.

13. Seek the support of the government.

14. Call upon insurance carriers, other purchasers of care, industry and organized labor to examine expanded consumer cost sharing, cost effective alternatives to existing coverages, and to carefully review any substantial expansion of existing benefits.

15. Seek a review by government of the cost impact of all existing federal regulations, to be completed by the end of next year.

The National Steering Committee is composed of the following:

AHA Chairman-elect Samuel Tibbitts, President of the Lutheran Hospital Society of Southern California; FAH's President-elect Andrew W. Miller, Senior Vice President, Hospital Corporation of America; Dr. Hunter of the AMA; Health Insurance Association of America President Robert Froehlke; Harold Buzzell, President of the Health Industry Manufacturers Association; Blue Cross Association President Walter McNerney; Virginia Knauer, former Presidential Special Assistant on Consumer Affairs; and C. S. Tsowas, General Electric Corp.'s consultant for Insurance Plans and Corporate Employee Relations representing the U.S. Chamber of Commerce.

Topical Treatment of Herpes Labialis With Chloroform — C. A. Taylor et al (Univ of Virginia School of Medicine, Charlottesville, VA 22904) *Arch Dermatol* 113:1550-1552 (Nov) 1977.

The efficacy of topical chloroform treatment of herpes labialis (HL) was evaluated in 50 patients with culture-verified HL. Treatment was begun within 48 hours of lesion onset, with either chloroform or camphor-in-oil placebo applied locally once a day for three days. Patients were observed daily by one investigator who also cultured and photographed the lesions. The photographs were evaluated by two other investigators. By direct observation, the time for scab formation was significantly less in the group treated with chloroform ($P < .01$). No difference in time to healing was noted. Blind evaluation of the serial photographs showed a trend for more rapid scab formation and healing in patients treated with chloroform, but the differences were not significant. The minimal benefit derived from topical chloroform therapy of HL does not appear sufficient to recommend its routine use.

Cimetidine in Treatment of Duodenal Ulcer — D. J. Hetzel et al (Royal Adelaide Hosp, Adelaide, South Australia) *Med J Aust* 1:317-319 (March 5) 1977.

In a double-blind trial performed at two centers, 67 outpatients with endoscopically confirmed duodenal (55) or pyloric canal (12) ulcers received cimetidine (34 patients) or placebo (33 patients) for six weeks. At six weeks complete healing of ulcers was significantly increased in patients receiving cimetidine (82%) compared with those receiving placebo (39%) ($\chi^2 = 11.27$; $P < .0008$). Patients receiving cimetidine had significantly less daytime pain and required less antacid than those receiving placebo. Gastric acid secretion measured one week after cessation of treatment showed no rebound hypersecretion of acid in patients who received cimetidine. The pretrial basal acid output of those patients whose ulcers failed to heal during cimetidine therapy was significantly greater than in those whose ulcers healed during treatment ($P < .001$). No side effects were encountered.

Cardiopulmonary Resuscitation by Lay People — I. Lund (Ulleval Sykehus, Oslo, Norway) and A. Skulberg, *Lancet* 2:702-704 (Oct 2) 1976.

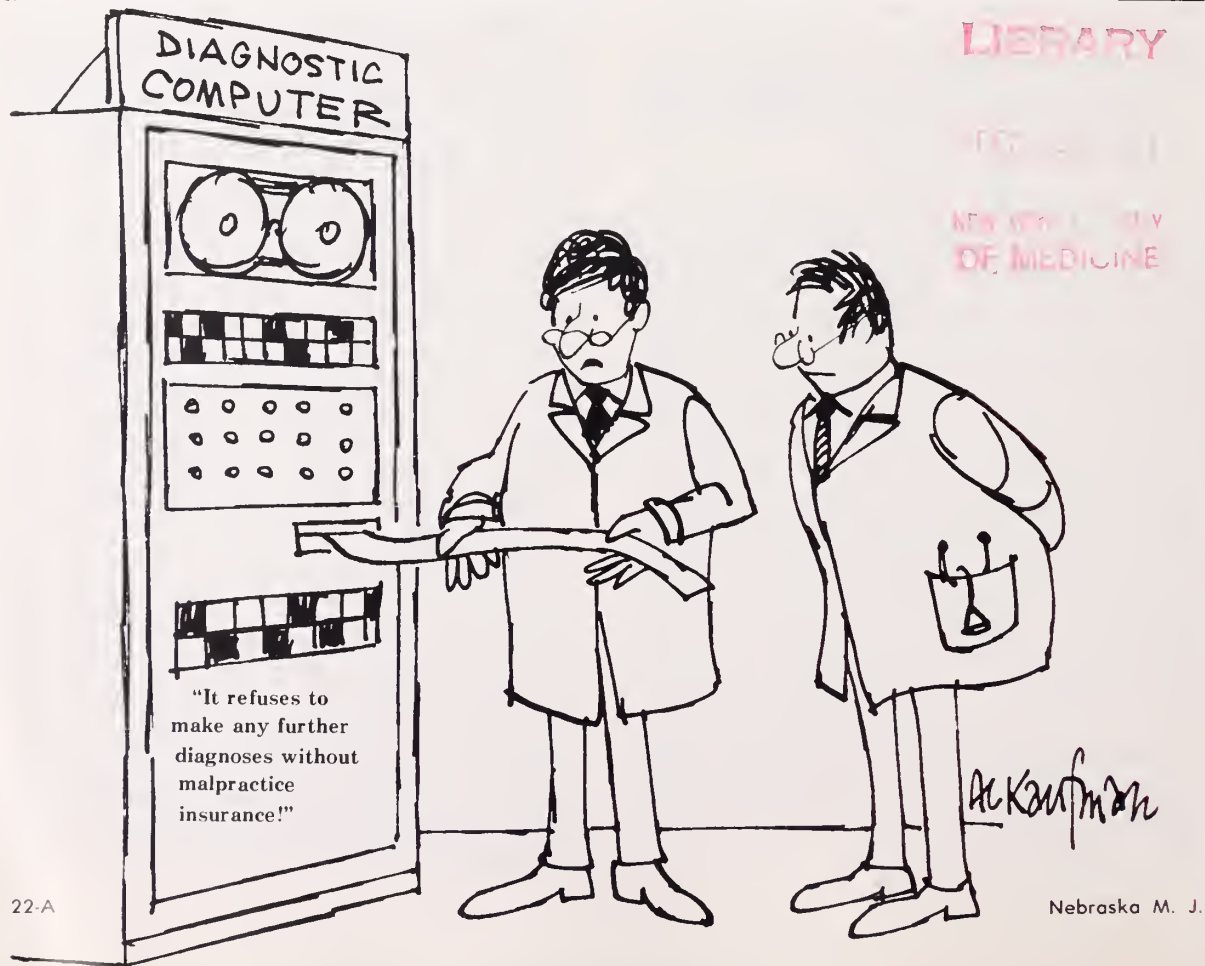
The survival rate in 75 of 631 patients with cardiac arrest in whom resuscitation was started outside hospital by lay persons was 36%. Only 8% survived when attempts at resuscitation were delayed until the arrival of an ambulance team that included an anesthetist and a specially trained nurse. These data show the importance of anoxia time (time from cessation of circulation to initiation of resuscitation) to the chances of survival after resuscitation, and support the idea that lay persons should be taught and encouraged to perform cardiopulmonary resuscitation.

Early and Late Results of Resection of Abdominal Aortic Aneurysms — K. Scobie et al (340 McLeod St, Ottawa, Ontario, Canada) *Can Med Assoc J* 117:147-150 (July 23) 1977.

Resection of the abdominal aortic aneurysm is being performed with decreasing operative mortality and morbidity. Among 190 patients undergoing this procedure between 1970 and 1975, 53 (28%) had a ruptured aneurysm and 137 (72%) a nonruptured aneurysm. Mean age was 66.2 years. Concomitant disease was frequent, 73% of patients having two or more associated diseases; the average number per patient was 2.25. Operative mortality in the group with ruptured aneurysms was 51%, and in the group with nonruptured aneurysms, 4%. Postoperative morbidity was 85% in patients with a ruptured aneurysm, 67% in those with imminent rupture before operation, and 34% in the others with a nonruptured aneurysm. Graft complications occurred in 15% of those with a ruptured aneurysm and in 9% with a nonruptured aneurysm. Among survivors of the operation, 73% and 81% of those with a ruptured and a nonruptured aneurysm, respectively, are known to be alive. In both groups causes of late death included infection or thrombosis of the graft and mesenteric thrombosis, as well as causes unrelated to the operation.

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For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days



- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice

- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (Federal Register, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

Her next attack of cystitis may require

the BactrimTM 3-system counterattack



ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of

Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

BALCONY

*The Nebraska
Medical
Journal*

March, 1978



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LIBRIUM® chlordiazepoxide HCl/Roche THE ANXIETY-SPECIFIC

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when

instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and con-

fusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts an liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Librium® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.



Roche Products Inc.
Manati, Puerto Rico 00701

The Nebraska Medical Journal

EDITOR-FRANK COLE, M.D., No. 13, Bishop Square
3901 So. 27th St., Lincoln 68502

MARCH 1978

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"Fun Night"

Tuesday, May 2

The Humor and Wit of Mark Russell

Mark Russell has been called many things, from a political satirist to just plain crazy. One thing is for sure, his special kind of political humor makes him a very funny man.

A performer with no particular political axe to grind ("I'm a confused independent," he says, "but I can be bought") he has been zinging Democrats and Republicans from Washington nightclubs since the days of the New Frontier. Russell's background includes engagements at some of America's top night spots and four record albums. He has often been a guest on many television shows, including The Tonight Show, Merv Griffin Show, Today Show, two David Frost Specials, a BBC special and five live one-man specials for the Public Broadcasting System. His syndicated column with the Los Angeles Times goes to over 100 newspapers.



East Hills Supper Club

NMA 110th Annual Session

Registration Forms for the Session and Ticket Forms
will be distributed in early April

ADVICE TO AUTHORS

The Editor of this Journal assumes no responsibility for opinions and claims expressed in the articles published herein.

Manuscripts to be presented for publication in the JOURNAL should be typewritten, double-spaced, on one side only of firm (not onion skin or flimsy), standard letter size (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title-page should be shown the title of the article, the name (or names) of the author, his degree and other significant credits. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Illustrations should be numbered and their locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be black (India ink) on pure white. Photographs should be on glossy paper and a minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

Manuscripts (original, not a carbon) should be sent directly to the Editor at the Journal's address.

Letters to the Editor submitted for publication should be prepared as above, and must carry the notation: To be Published.

Manuscripts not accepted for publication will not be returned to the author.

Reprints should be ordered from the printer, Norfolk Printing Co., Inc., P. O. Box 278, Norfolk, Nebr. 68701.

Treatment of Severe Coronary Artery Disease With 5, 6, and 7 Saphenous Vein Bypasses — G. P. Geisler et al (3434 Swiss Ave, Suite 404, Dallas, TX 75204) Ann Thorac Surg 24:246-251 (Sept) 1977.

One hundred thirty-one consecutive patients who receive 5, 6, and 7 bypass grafts are analyzed. Ages ranged from 31 to 74 years. The male-to-female ratio was 7:1. As an indication of severity of disease, 25% were classified as having impending myocardial infarction and 46.6% were classified in New York Heart Association Functional Class IV. Left ventricular function was impaired in 37.4%, and 30% of the patients had left main coronary obstruction. Nonfatal perioperative myocardial infarction occurred in 4.6%. The hospital mortality was 3%. One hundred percent follow-up (5 to 55 months) revealed four late deaths, three presumably of cardiac origin. Only seven patients in the postoperative follow-up group complained of angina; one has since undergone successful reoperation.

100 mg

250 mg

500 mg



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tolazamide, Upjohn

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Role of Aspiration Breast Biopsy — J. E. Devitt (Ottawa Civic Hosp, Ottawa, Ontario, Canada) and R. H. Curry *Can J Surg* 20:450-453, (Sept) 1977.

Review of 100 consecutive aspiration breast biopsies disclosed that this technique failed to identify 11 of the 33 breast cancers; however, it identified three breast cancers that were not recognized by clinical examination. In one patient who had a fibroadenoma suspicious cells were seen in the material sent for cytologic examination. A negative aspiration biopsy does not contraindicate tissue biopsy when the clinical findings suggest cancer. Aspiration biopsy can uncover clinically unsuspected cancers. When the lesion appears to be malignant on a clinical basis, aspiration biopsy can obviate formal biopsy.

Impaired Sphincter Control in the Dyspneic — J. S. Jones (Royal Victoria Hosp, Kent, England) *Lancet* 2:532-533 (Sept 10) 1977.

Six case histories illustrate how altered control of micturition is an occasional accompaniment of dyspnea in patients over 50 years old. Recognition of this problem can be a step towards understanding the great disability of some dyspneic patients.

Accidental Percutaneous Hexachlorophane Intoxication in Children — F. Goutieres (Hospital St Vincent de Paul, Paris, France) and J. Aicardi, *Br Med J* 2:663-664 (Sept 10) 1977.

Eighteen children, 3 to 36 months old, who were accidentally intoxicated by a talc powder containing 6% hexachlorophane (HCP), were observed. All had evidence of severe cerebral dysfunction. Involvement of the spinal cord was noted in eight, with definitive paraplegia in two. Four infants died. Massive intramyelinic edema of the brain and spinal cord, found in autopsies of two patients, seems to account for the clinical picture of intracranial hypertension and of spinal dysfunction. Definitive paraplegia was probably due to spinal hemorrhages occurring as mechanical complications of edema. Absorption of HCP through an intact skin probably resulted from prolonged use.

Tablets **Percocet®-5**

DESCRIPTION Each tablet of PERCOCET®-5 contains 5mg oxycodone hydrochloride (WARNING: May be habit forming), 325mg acetaminophen (APAP).

INDICATIONS For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS Hypersensitivity to oxycodone or acetaminophen.

WARNINGS **Drug Dependence** Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of PERCOCET®-5, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, PERCOCET®-5 is subject to the Federal Controlled Substances Act.

Usage in ambulatory patients Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using PERCOCET®-5 should be cautioned accordingly.

Interaction with other central nervous system depressants Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with PERCOCET®-5 may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Usage in pregnancy Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, PERCOCET®-5 should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Usage in children PERCOCET®-5 should not be administered to children.

PRECAUTIONS **Head injury and increased intracranial pressure** The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions The administration of PERCOCET®-5 or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special risk patients PERCOCET®-5 should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

ADVERSE REACTIONS The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include euphoria, dysphoria, constipation, skin rash and pruritus.

DOSAGE AND ADMINISTRATION Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. PERCOCET®-5 is given orally. The usual adult dose is one tablet every 6 hours as needed for pain.

DRUG INTERACTIONS The CNS depressant effects of PERCOCET®-5 may be additive with that of other CNS depressants. See WARNINGS.

DEA Order Form Required.

Endo Inc.

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November 1977

ED 148P

FOR MODERATE TO MODERATELY SEVERE PAIN

Acetaminophen with the narcotic difference

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The narcotic component in PERCOCET®-5 is oxycodone, which is readily absorbed and provides dependable oral analgesia—usually within 15 to 30 minutes. Oxycodone can produce drug dependence of the morphine type and should be prescribed with the same degree of caution appropriate to the use of other narcotic-containing medications.

Acetaminophen is a non-narcotic analgesic widely used for aspirin-sensitive patients. Equivalent to aspirin in analgesia, it complements the pain relief provided by oxycodone.

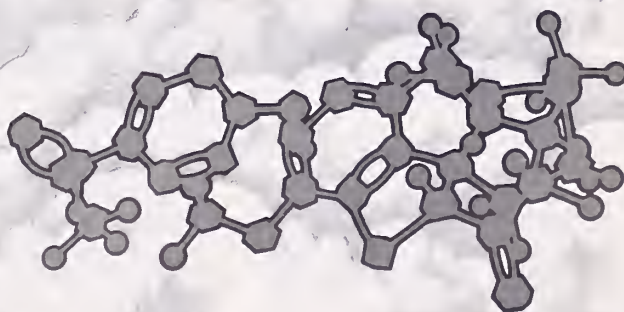
The usual dose of PERCOCET®-5 is one tablet every six hours, providing convenience and economy for your patients. PERCOCET®-5 is ideally suited for your patients with aspirin sensitivity, with hemostatic disturbance, with peptic ulcer or on anticoagulation therapy.

Tablets
Percocet-5

each scored tablet contains 5 mg oxycodone HCl
(WARNING: may be habit forming) and 325 mg
acetaminophen



**When aspirin is
contraindicated.**



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Please see facing page for Brief Summary of prescribing information.

The Paper Lion George Plimpton

George Plimpton is one of America's most interesting and innovative writers. Plimpton does not merely cover sports, his writing digs into the insides of the people who make sports happen. Plimpton feels the emotions they experience and undergoes the mental and often physical punishment they endure.

A graduate of Harvard and Cambridge, George Plimpton has played tennis with Pancho Gonzales, golf with Sam Snead and bridge with Oswald Jacoby. He taught three rounds with Archie Moore, pitched an endless inning to a line-up of major-league All-Stars, was last-string quarterback for the Detroit Lions, swam against Dan Schollander, and even played percussion with the New York Philharmonic under Leonard Bernstein.

His books include PAPER LION (the best selling sports book in history), OUT OF MY LEAGUE, and THE BOGEY MAN.



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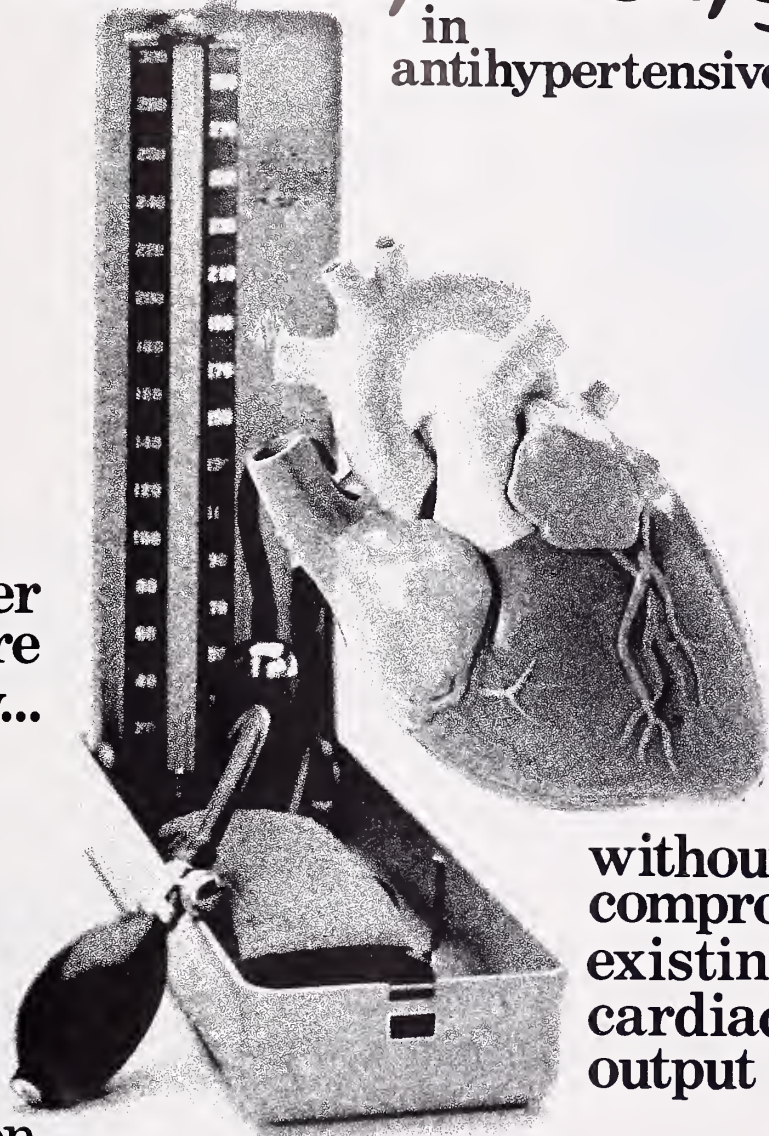
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to lower
blood pressure
effectively...



without
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output

in hypertension

TABLETS: 250 mg, 500 mg, and 125 mg

ALDOMET[®] (METHYLDOPA | MSD)

helps lower blood pressure effectively...

usually with no direct effect on
cardiac function—cardiac output
is usually maintained

ALDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if previous methyldopa therapy has been associated with liver disorders.

It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

For a brief summary of prescribing information, please see following page.

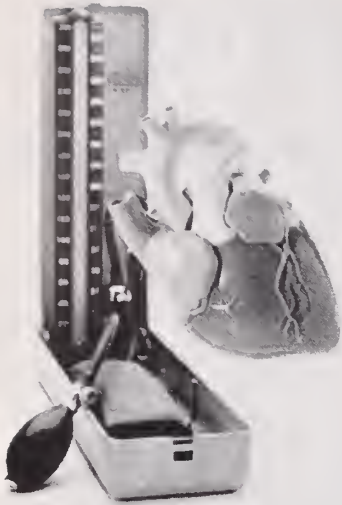
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helps lower
blood pressure
effectively...
usually with no
direct effect on
cardiac function—
cardiac output is
usually maintained



Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive,

problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, occasionally with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Pregnancy and Nursing: Use of any drug in women who are or may become pregnant or intend to nurse requires that anticipated benefits be weighed against possible risks; possibility of fetal injury or injury to a nursing infant cannot be excluded. Methyldopa crosses the placental barrier, appears in cord blood, and appears in breast milk.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: urinary uric acid by the phosphotungstate method, serum creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular

disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia. Positive tests for antinuclear antibody, LE cells, and rheumatoid factor.

Allergic: Drug-related fever, lupus-like syndrome, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third months of therapy; increased dosage or adding a diuretic frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 500.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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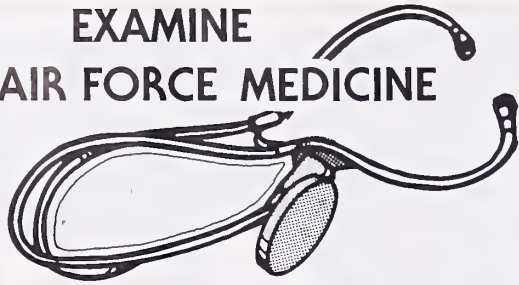
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What Do Family Physicians See in Practice?

— A. M. Warrington et al (147 West 16th St, Vancouver, BC, Canada), Can Med Assoc J 117:354-356 (Aug 20) 1977.

Health care problems dealt within their practices were recorded by seven family physicians over a period of one year (two others recorded for three months), each diagnosis being coded according to the Canuck Disease Classification Index. Problems were classified into four types: physical, psychosocial, diseases of choice (or lifestyle), and diseases of social impact. More than 85% of the 23,108 problems recorded were physical in origin and had physical manifestations. More time was spent on routine checkups and treatment of respiratory disease than on any other activity. Venereal disease and alcoholism were infrequent problems. The family physician is in a favorable position to act as health educator and counsellor and must be thoroughly trained in the physical aspects of disease.

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Recognition of Fifty-Year Practitioners
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TUESDAY — MAY 2

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Water Beds — A Potential Source of *Pseudomonas aeruginosa* — K. M. Elhag et al (St Bartholomew's Hosp, London, England) J Hygiene 79:103-106 (Aug) 1977.

Water beds in use in St Bartholomew's Hospital were found to be contaminated with *Pseudomonas aeruginosa*. The addition of sodium hypochlorite, giving a final concentration of 200 parts/10⁶ available chlorine, was found to be effective in preventing microbial contamination over a six-month study period.

Artificial Sweeteners and Human Bladder Cancer — G. R. Howe et al (A. B. Miller, National Cancer Institute of Canada, Univ of Toronto, Ontario, Canada) Lancet 2:578-581 (Sept 17) 1977.

A positive association between the use of artificial sweeteners, particularly saccharin, and risk of bladder cancer in males was observed in a case-control study of 480 men and 152 women in three Canadian provinces. The risk ratio for ever vs never used is 1.6 for males ($P = .009$, one-tailed test), and an important dose-response relationship was obtained for both duration and frequency of use. The population attributable risk for males is estimated a 7%, though for diabetics, who have a similar risk ratio for artificial sweetener use as nondiabetics, the attributable risk is 33%.

Fever in the First Eight Weeks of Life — K. B. Roberts (Sinai Hosp of Baltimore, Baltimore, MD 21215) and M. S. Borzy, Johns Hopkins Med J 141:9-13 (July) 1977.

Sixty-one febrile infants in the first eight weeks of life were evaluated for serious, treatable illness. Infants with bacteremia could not be distinguished from nonbacteremic infants by height of fever, white blood cell count, absolute number of juvenile or mature polymorphonuclear leukocytes, or the presence of a focus of infection (meningitis excluded). The examiners' overall assessment ("clinical judgment") correctly identified eight of the nine infants with bacteremia as not being "well;" one 2-week-old with group B streptococcal bacteremia was "missed" clinically. This points up the limitation of clinical judgment in assessing febrile infants in the age group studied and supports an aggressive approach in the management of very young febrile infants.

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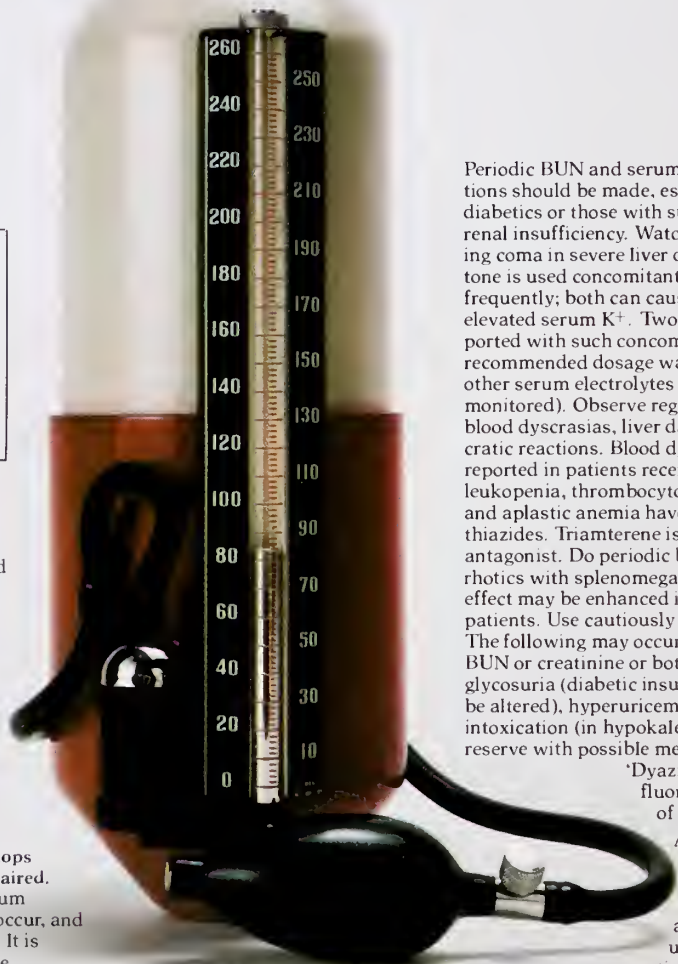
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THE NEBRASKA MEDICAL JOURNAL

DO HAPPY PEOPLE LIVE LONGER?

There has been a disturbing number of writings, dealing with the effect that the mind may have on the body, and on disease. Recovery from spondylitis and hypertension, and lowering of blood sugar have been attributed to thinking and to a change in mental attitude. And so I wonder, since I am not unconvinced, and since I will go along with this novel but not recent philosophy, if thinking pleasant thoughts, thinking down-right happy thoughts, if thinking you want to get well can get you well, what then of the lucky person who does not wait for illness, but thinks beautiful thoughts all his life, will he be freer of disease than his neighbors?

And will he live then beyond the life span that is average for everybody else?

The conclusion is inescapable, once one accepts the idea that wanting to live, that optimism, that gaiety, that laughter can get one well. If you can throw off inflammation, resist degeneration, and ward off infection by assuming a sense of well-being, can we not push farther into the background the time of being gathered to our fathers, by being happy, by smiling and laughing, all the days of our lives? And which of you by being anxious can add one cubit to his span of life?

Do the rich, who seem happier than the poor, outlive the poor? Did masters die later than their slaves? Rich is easy, but it is hard to measure happy. Still, it seems possible, and it may be sensible to ask. Do worriers predecease those who radiate confidence? Do happy people live longer?

There is room, there is a need, for assurance, for cheer, even humor, at the bedside; it may help the patient more than medicine. And can we not use whatever gives fun and pleasure as tools in our materia medica; and since we cure retail while we prevent wholesale, can we not use these measures every day, so that we are less somber, that we entertain pleasant thoughts, and thereby live longer?

Smile.

—F.C.

ON STAYING HOME WHEN
YOU HAVE A COLD

There is a great temptation to come to work when you are not feeling well. Some of this is explained by a sense of duty, or by wanting to set a record, and even a desire to save sick leave. If you are a key person, if you are due to anesthetize someone and cannot bring yourself to destroy the operating schedule, you may feel compelled to come in.

There is also a temptation to stay home, and this is as easily explained; you do not feel capable of working, and you are sure to be more comfortable at home.

But there are other motives. You will recover more rapidly if you do not come to work. And you are sure to spread what you have among your fellow-workers or patients if you insist on coming in when you have a cold.

Which is better? How many work days will be lost if you come in but infect a dozen others? Should a doctor say, the patients must be seen, or is it a kindness to wait until you can no longer give them what you had?

There is a happy medium somewhere, but I do not believe in gray areas. If you are coughing and sneezing, stay home. It is good for you, and it will be even better for everybody else.

—F.C.

OUR ENEMIES

Our enemy, the microorganisms.

Consider the tiny plants, the bacteria and the filtrable viruses. Do they *mean* to do us in when they render us unhealthy? As they whip their flagellae about, do they swim thoughtfully? When they release toxins, do they do so with purpose? Do they triumph when we cough blood, have they won when we are with abscesses? And when we have lost everything, do they seek to devour us, as the hawk who has downed a fieldmouse, or the lion who has brought down a gazelle?

Our enemy, us.

We overeat, we drink, we do not brush

our teeth, we smoke. We do not keep appointments, we do not exercise, we pollute, we produce carcinogens, we make war.

Our enemy, the animals.

If we feed on plants and animals, it is not illogical that they feed on us. It is done, animals kill weaklings, nor are we always safe from bears and tigers.

Our enemy, disease.

We die of degeneration, of inflammation, injury, things we are born with, and malignancy, and the last gives me pause.

For we do ourselves in when we have cancer. It is our own cells that destroy us, our own tissues have turned against us, and the word suicide comes to mind. If the lemmings drown, do we not execute ourselves when it is time?

We are like a mechanical toy or a spinning top that is running down, that wobbles for a little while, makes small futile gestures to stay, and finally stops. We are being told: it is time.

—F.C.

ON NOT SAVING LIVES

It has been suggested that capital punishment be accomplished by intravenous injection of drugs generally used to provide anesthesia in surgery. It is not at all a new idea; it may be less painful than hanging or shooting. But who will insert the needle?

If a doctor puts the needle into the doomed person's vein, is he helping to put someone to death? Would you perform venipuncture and then leave, knowing that someone else will later, and when you are far away, attach the deadly solution to the needle. Will an anesthesiologist be called on to do it, and to suggest the drug and the dose? I would not.

What of the physician who long ago stood by at a flogging, or who waits at a prize fight until one of the battlers is severely injured? What of the doctor in battle, and the one who stands by at an execution, to pronounce someone dead, someone who has just been put to death while the physician, whose duty it is to save life, waits to be certain that the prisoner is surely dead?

We are here to save life. Is it unethical for

us to participate in injury and in death? If someone is to be put to death, and we make it less painful, are we somehow involved in the death process? If we watch while injury is inflicted, do we injure?

There are other things we are called on to do, but the point is the same. Shall we stand by and do we somehow contribute to an act we find loathesome, and to something we know when we leave medical school, and probably when we enter it, we must never be a part of?

I won't put the needle in the vein. And I won't show anybody else how to do it, not for that purpose.

—F.C.

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Some journals charge authors for publishing articles that go over two pages; we haven't done it yet.

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So please: no 18-page manuscripts. They are not as likely to be accepted. Remember: *half as long is twice as good*. Two-page articles (four pages in the manuscript) are jewels; they sparkle. People read them. There is room for them, and there is room for other articles, too. Your long manuscript may crowd out one written by somebody else; and somebody else's long article may not leave room for *yours*.

Keep it short: see?

—F.C.

Abstracts:

Fourth Annual University of Nebraska Medical Center Student Research Forum: 1977; Friday, November 11, 1977

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CHARACTERISTICS OF BONE MARROW STROMAL CELLS GROWN IN CULTURE. Ronald W. Anderson, J. G. Sharp and W. W. Stinson, University of Nebraska Medical Center, Omaha, Nebraska.

The microenvironment of hematopoietic stem cells has been implicated as playing a role in the control of stem cell differentiation. In the present investigation bone marrow stromal cells have been grown in culture to determine the influence of these cells upon the stem cell compartment. The cultured cells have been characterized morphologically and a preliminary assay of their ability to induce granulocyte-monocyte colony (CFU-c) formation has been performed. Femoral bone fragments were suspended in agar and supplemented McCoy's 5A medium employing a method similar to that of Daniels (Anat. Rec. 184:388, 1976). Phase contrast microscopy demonstrated

small round cells of uniform size appearing the day after initiation of the cultures. These were probably blood mononuclear cells which had migrated out of the bone fragments. By day 5 large ovoid cells containing an oval nucleus with a prominent nucleolus and numerous basophilic cytoplasmic granules had appeared. Stellate fibroblastoid cells, first seen in a few cultures by day nine, appeared in 66% of the cultures on day 15, and grew to confluence by day 40. Acellular matrix accumulated between cell clusters. Histochemical procedures demonstrated the stellate cells had oval nuclei containing one or more nucleoli. Their cytoplasm contained basophilic granules, vacuoles, ribosomes and methanamine silver positive material around their periphery. Electron microscopy verified the presence of numerous ribosomes and demonstrated aggregates of immature fiber components at the cell periphery. Such cells appeared equipped to produce acellular

matrix material. When either cultured stromal cells or concentrated culture supernate were co-cultured with normal bone marrow cells, there were no striking increased in granulocyte-monocyte colony formation, with or without the presence of colony activation factor, attributable to the cultured stromal cells or their supernate.

THE USE OF INSTRUCTIONS TO FACILITATE GENERALIZATION OF PARENT TRAINING FROM LABORATORY TO HOME SETTINGS, Mary Jo Andrews, Gail Sunderman, and J. Michael Leibowitz, MCRI, The University of Nebraska Medical Center, Omaha, Nebraska.

This study analyzed the training of a mother to modify three types of inappropriate behavior in her retarded three-year-old tantruming, disruptive, and noncompliant child. Sessions were held three times a week over a period of seven months in a laboratory setting where the child was required to comply with 20 predetermined instructions given by the mother. Each instruction consisted of the placement of a specific toy at one of five randomly determined locations. Modification of four subclasses of the mother's attention (praise, attention to inappropriate behaviors, physical guidance, repetition of instructions), the use of food treats, a period of free play, and the use of a brief room timeout were utilized to increase compliance and decrease inappropriate child behaviors. The effectiveness of the training program was demonstrated by the sequential introduction of techniques for modifying each subclass of parental behavior in a multiple baseline design across behaviors. Concurrently, similar data were collected in the home in a comparable setting where minimal change was noted in both the behavior of the mother and the child. Instructions were then given to facilitate generalization of parental behavior management techniques from the laboratory to the home. Following the instruction to use laboratory taught techniques at home, both the mother's and child's behavior changed within one session. Subsequent reversal of the mother's use of these techniques at home indicated that it was the use of these techniques that was responsible

for the child's behavior change. Home data on three classes of the child's behavior collected by the mother throughout the duration of the study (tantruming, head-banging, and walking alone) also indicated no change until the mother was again instructed to use the previously taught techniques. A follow-up session conducted three months later in the laboratory indicated that the techniques were still being used effectively by the mother.

METABOLIC PARAMETERS OF THE VASCULAR WALL AND ITS COMPONENTS, Stephen P. Bruttig, Dept of Physiology and Biophysics, University of Nebraska College of Medicine, Omaha, NE

Presently, transport of macromolecules from the vascular spaces to tissue fluid is thought to occur at capillary and post-capillary venular sites. At both of these sites, the endothelial cell is thought to regulate this transport. However, controversy exists as to whether capillary transport of macromolecules is metabolically supported or not. To begin a study of the metabolic support of macromolecular transport, a study of the basal metabolism of the vascular wall, as well as its components, was begun. Manometric determination of oxygen consumption (V_{O_2}) was performed on human umbilical arterial (USa) and venous (USv) segments, arterial (ECa) and venous (ECv) endothelial cells (8-10 days in culture), and venous fibroblasts (Fv). Cellular ATP concentrations (by the Luciferin-Luciferase reaction) and total protein concentrations (by the Lowry method) were also determined, under basal conditions, for ECv. V_{O_2} data include: USa = $15.77 \mu\text{l O}_2/\text{min}/\text{mg dry wt.}$; USv = $55.48 \mu\text{l O}_2/\text{min}/\text{mg dry wt.}$; ECa = $195 \text{ pl O}_2/\text{min}/\text{cell}$; ECv = $460 \text{ pl O}_2/\text{min}/\text{cell}$; Fv = $502 \text{ pl O}_2/\text{min}/\text{cell}$. Mean ECV ATP concentration was $5.40 \text{ pM} \times 10^{-4}/\text{cell}$ and mean ECv protein concentration was $32.95 \text{ pg}/\text{cell}$. These results are consistent with experiments comparing ECa and ECv prostaglandin production (Joyner and Strand, *Microvasc. Res.*, in press). They indicate the umbilical venous vascular walls are more metabolically active than umbilical arterial vascular walls.

IMMUNOCYTOCHEMICAL STUDIES OF TESTICULAR BINDING SITES FOR ANTI-LUTEINIZING HORMONE, Carl B. Caton and Paul J. Gardner, University Nebraska Medical Center, Omaha, Nebraska.

Androgen synthesis by the adult testis is controlled by the pituitary gonadotropin, luteinizing hormone (LH). There is considerable evidence that testicular Leydig cells are the major source of androgens. Biochemical and morphological studies suggest the LH binds to Leydig cells, probably at the plasma membrane. Others report the existence of LH binding sites in Leydig cell cytoplasm and in elements of the seminiferous tubule. Thus, the exact sites of LH action are not known. In the present investigation, the unlabeled antibody, peroxidase-antiperoxidase (PAP) complex technique was used to study the cellular and subcellular distribution of binding sites for anti-LH.

The pituitary glands and testes of normal adult male rats were processed for light and electron microscopic study by routine methods. Sections were incubated sequentially in anti-LH, goat anti-rabbit IgG, and PAP, with appropriate intervening buffer washes. They were then treated with diaminobenzidine. Ultrathin sections were also treated with OsO_4 to render the reaction product electron dense. Method controls consisted of omitting one of the steps of the staining sequence, while specificity was tested by using a series of dilutions of anti-LH or anti-LH previously absorbed with LH. Staining intensities were measured at the light microscopic level with a Leitz MPV microscope photometer.

At the light microscopic level, reaction product was localized in pituitary gonadotrophs and in Leydig cells. All staining appeared to be cytoplasmic. Staining was also observed inconsistently in the peritubular boundary tissue. Specificity of the staining reaction was supported by quantitative evaluation. No staining was detected in the testis at the ultrastructural level, although staining was heavy on the secretory granules of gonadotrophs.

The results of this preliminary investigation support the findings of others that LD binds to Leydig cells and, possibly, to other testicular elements and suggest that it may be possible to localize binding sites for LH in the testis at the ultrastructural level by this technique.

PATERNAL ROLE PERCEPTION: A PILOT EXPLORATION, Brenda S. Cherry, The University of Nebraska Medical Center, Omaha, Nebraska.

The purpose of the study is to explore and describe the perceptions of fathers of more than one child and first time fathers' perceptions in regard to their paternal role.

Seventeen fathers for the first time and eighteen fathers of more than one child completed the Paternal Role Perception Questionnaire designed by the student investigator. Purposive sampling was utilized to obtain the above subjects during visiting hours on the post partum unit in the midwestern private general hospital. Fathers completed the questionnaire on the post partum unit.

Subjects responded to questions designed to elicit information under the variables socialization, current stimuli, and social norms which were assumed to have an association with paternal role perception. Questions concerning demographic characteristics and describing paternal role perceptions were also responded to by subjects. Responses were presented in the form of frequencies and medians of responses.

Analysis revealed that fathers of more than one child had more positive perceptions of paternal role than did first time fathers. Some evidence of incorporation of values held by subjects' fathers was observed from responses. The showing of nurturing behaviors was one of the more pronounced differences between what subjects perceived their fathers' roles were and their perceptions of what their roles should be.

The conclusions made were that fathers were confident in their ability to plan for the future needs of their children and fathers are becoming more affectionate and less authoritarian in their paternal behaviors.

A BIOFEEDBACK APPARATUS FOR TEACHING PURSED-LIP BREATHING AND EXPIRATORY PROLONGATION TO PATIENTS WITH CHRONIC LUNG DISEASE,

Thomas Clanton, Mark Kass, Michael McNally, Francis Clark, and Irving Kass, University of Nebraska Medical Center, Omaha, Nebraska.

Breathing against added expiratory resistance as in "pursed-lip breathing" and the slowing of respiratory rate have been shown to aid in the relief of dyspnea in patients with chronic pulmonary disease. We have built an apparatus that can be used to train patients to perform pursed-lip breathing and prolonged expiratory durations so that the physiologic and psychologic effects of these maneuvers may be evaluated.

The expiratory signal is sensed by a microphone placed in front of the patient's mouth that responds to the sound of air turbulence created during expiration. The signal is then rectified and used to charge an R-C circuit which creates a voltage pulse during the expiratory phase. This signal is then used to drive a lamp which gives the patient visual feedback during his expiratory effort. An auditory signal is produced at the end of an adjustable time period from the beginning of expiration. In this way, the duration of the desired expiratory phase may be adjusted. A second visual signal appears during the time interval between when the patient ceased expiration and the end of the desired expiratory duration.

This apparatus shows promise of becoming an effective means of training chronic lung patients how to adjust their own respiratory activity for maximal relief during periods of dyspnea and relaxation during periods of stress.

PROPERTIES OF PHOSPHORIBOSYL-PYROPHOSPHATE [PRPP] SYNTHETASE IN NORMAL AND LEUKEMIC HUMAN WHITE BLOOD CELLS. Mary K. Danks and Eric M. Scholar.

PRPP is an important intermediate in the biosynthetic pathway for purine and pyrimidine nucleotides and plays a role in the regulation of purine metabolism. The formation of PRPP from ribose-5-phosphate and

ATP is catalyzed by the enzyme PRPP synthetase. Alteration of the activity of this enzyme has been implicated in several disease states.

Since several antineoplastic agents become active pharmacologically through reaction with PRPP and because PRPP synthetase is a regulatory enzyme in nucleotide synthesis, it was decided to characterize its properties in normal lymphocytes and compare these with those of leukemic cells.

Normal lymphocytes and leukemic cells were isolated from peripheral blood using the Ficoll-Hypaque technique. Cell free extracts were prepared by sonication. Enzyme activity was determined by production of $^{14}\text{C}\text{O}_2$ in a coupled reaction with ^{14}C -labelled orotic acid in the presence of orotidylate pyrophosphorylase and orotidylate decarboxylase. The $^{14}\text{C}\text{O}_2$ was collected on a Whatmann 3MM filter disc inserted in the cap of the reaction vial and saturated with NCS tissue scintillator. Enzyme activities, expressed as nmoles/mg protein/min., were as follows: normal lymphocytes, 2.39; chronic lymphocytic leukemia, 5.48; acute lymphocytic leukemia, 10.50; acute myelocytic leukemia, 5.34; and PHA transformed lymphocytes, which resemble leukemic blast cells in some aspects, had a value of 10.55 after 72 hours incubation.

The K_m for ATP in the leukemic cells varies from that of the normal cells, and the pharmacological significance of this observation is under investigation.

TRANSLATIONAL CONTROL OF UTERINE PROTEIN SYNTHESIS BY ESTRADIOL, Terrence M. Donohue, Jr. and Kenneth L. Barker, The University of Nebraska Medical Center, Omaha, Nebraska.

Estradiol has been shown to have direct effects on uterine transcription. The purpose of these studies was to determine whether estradiol might also exert an effect on uterine translation by measuring the total translation time of uterine protein synthesis in general as well as that of a specific estrogen-induced uterine protein, glucose-6-phosphate dehydrogenase (G6PD). Twenty μCi of ^3H -leucine were administered directly

into the uterine lumen of control and 12 hr estradiol-treated rats for short pulse-labeling periods (1 to 12 min). The amount of acide-insoluble radioactivity in uterine proteins of the postmitochondrial fraction, which contains nascent and released proteins, and the postribosomal fraction, which contains released proteins as well as immuno-precipitable uterine G6PD, were measured as a function of time. It was found that the time interval required for the linear incorporation of radioactivity into total uterine soluble (released) proteins relative to that in total proteins (nascent + released) was significantly shorter in estradiol-treated rats. This latter measurement gives the half-time required for the cell's population of ribosomes to translate the mRNA from its 5' end to its 3' end and is thus a measurement of the rate of polypeptide elongation. When this technique was used to measure the "half transit time" of uterine G6PD, it was found that this time was also shortened. Thus, the shortening of this time interval by estradiol indicates that the hormone increases the rate of polypeptide elongation and it is estimated that this parameter is increased as much as 2-fold during the synthesis of G6PD *in vivo*.

ON RELIGIOUS CONVERSION AND BRAINWASHING — John V. Fernandez, Nebraska Psychiatric Institute, Omaha, Nebraska.

This paper explores the psychopathophysiology of sudden religious conversion and brainwashing. It is of practical interest to psychiatrists who could use this knowledge to better understand the process of dramatic change of beliefs in affected patients. Pavlov studied the conversion experience and described four stages of the process: the equivalent phase, the paradoxical, the ultra-paradoxical and the hypnoidal phases. The true conversion occurs in the paradoxical and the hypnoidal phases. The breakdown of a person can be induced by overloading him with stimuli, by putting him in a state of sensory deprivation or by using physical methods such as drugs or modified leucotomy. However, to sustain the new beliefs regular followup is very important.

Adolescence is the age group most vulnerable to conversion. Certain personality types such as the extrovert and the fanatic are relatively accessible to conversion techniques while stable, calm or obsessive people are much more difficult to change. Conversions are more common in times of turmoil and social upheaval and further research is called for to increase our knowledge in this field in order to aid psychiatrists who treat such patients and to help society protect itself from undesirable ideologies, an admittedly controversial issue.

Numerous discussions of sudden conversions are cited from the psychiatric, psychological, religious, anthropological and fictional literature, all of which seem to converge independently upon the basic concepts presented herein.

CHANGES IN LYMPHOCYTE SPECIFIC GRAVITY IN MALIGNANT DISEASE AND PREGNANCY, Robert N. Gould, Department of Anatomy, University of Nebraska Medical Center, Omaha, Nebraska.

The cytoplasmic refractive index of the cytoplasm of circulating lymphocytes has been shown to increase during immunological activity. This parameter is presumably a measure of the lymphocyte protein concentration. If this is true, changes in LCRI should be mirrored by changes in lymphocyte specific gravity. As only a proportion, albeit a significant proportion, of the circulating lymphocytes seem to be involved in the change in LCRI, determination of mean lymphocyte specific gravity would be unlikely to demonstrate a correlation. Accordingly, a discontinuous ficollhypaque density gradient has been used to determine the density profile of circulating blood lymphocytes. Both LCRI and density profiles have been determined in lymphocytes obtained from pregnant women and from patients with malignant disease. The density profiles and LCRI showed the expected good correlation in both conditions. In the last trimester of pregnancy, there was both a significant increase in the number of lymphocytes with a high LCRI and a similar increase in the number of heavy dense cells. A similar phenomenon was observed in

patients with malignant tumors. Our data, therefore, although admittedly preliminary, would support the hypothesis that both LCRI and density profile are measuring the same phenomenon, probably changes in the lymphocyte cytoplasmic protein concentration.

THE NATURE OF ROLE TRANSITION OF THE INDIVIDUAL WITH CANCER: A PILOT EXPLORATORY STUDY, Nancy

Ann Harms, The University of Nebraska Medical Center, Omaha, Nebraska.

The problem chosen for study was: "What is the nature of the role transition of the individual with cancer?" The rationale for consideration of this problem was based on the lack of empirical study in this area as well as the high incidence of cancer today. Another factor considered was the support which cancer patients frequently need as they live with the diagnosis of cancer and who provides such support for them.

Thirty individuals, ages 25-64, were interviewed in the clinic and hospital settings of a large metropolitan hospital and asked to complete a questionnaire. Demographic data as well as information relating to their role transition were obtained. Individuals were asked to describe themselves using independent and dependent terms before their diagnosis and during their present illness, as well as how they perceived their family's, the doctors' and the nurses' attitudes toward them. They were also asked to rank their most effective support mechanisms. On the basis of their responses, role conflict, role transition and role insufficiency prior to and following a diagnosis of cancer were determined according to specified criteria. Families were identified as being most important to the majority of clinic and hospital patients. Spouses were listed as providing the most support while talking was the most effective support mechanism for both groups.

Conclusions drawn were that individuals may experience role conflict, role transition and role insufficiency after a diagnosis of cancer. Family members, especially spouses, will need support in order to be supportive. Nurses need to be aware of the benefits of talking with cancer patients.

EVALUATION OF THE ROLE OF CULTURED THYMIC EPITHELIUM IN THE IN VITRO INDUCTION OF T-LYMPHOCYTE DIFFERENTIATION, Charles M. Harper, T. W. Bauer, and J. G. Sharp, University of Nebraska Medical Center, Omaha, Nebraska.

Evidence suggests that the differentiation and immunological maturation of T-lymphocytes within the thymus involves an interaction of T-cell precursors with thymic reticuloepithelial (TRE) cells. In order to investigate the nature of this interaction, TRE-cells were grown in culture using a modification of the methods of Wekerle et al. (Eur. J. Immunol. 3:745, 1973) and Waksal et al. (Ann. N.Y. Acad. Sci.) and subsequently tested for their ability to induce PHA responsiveness in splenocytes from neonatally thymectomized rats.

Adherent TRE-cells were cultured at 37°C in 25cm² Corning T-flasks in MEM-Hanks medium and 20% fetal calf serum. Suspensions of 2x10⁶ spleen cells from neonatally thymectomized rats were co-cultured *in vitro* with confluent TRE-cell monolayers, fibroblasts, or with 2.5x, 7.5x or 25x concentrated supernatant from confluent TRE-cell cultures. Spleen cells were harvested from the monolayers and cultured for 4 days with either PHA, LPS, or no mitogen. 1 μ Ci of H³-thymidine was added to each culture on the third day of incubation. The cultures were harvested and the H³-thymidine uptake into the acid insoluble cell fraction determined as a measure of the proliferative response to the mitogen. Spleen cells co-cultured with fibroblasts showed no significant response to the mitogens, while spleen cells co-cultured with TRE-cells or with low concentrations of supernatant showed a small but significantly increased proliferative response to PHA when compared to the controls (i.e. cultures with no mitogen). The response to LPS was only minimally increased. Splenocyte DNA synthesis was inhibited by high concentrations of supernatant. Thus, co-culture of spleen cells from neonatally thymectomized rats with TRE-cells or their supernatant induced an increased response to a T-cell specific mitogen (PHA). These results suggest that the interaction of T-cell precursors with thymic

epithelial cells may be investigated *in vitro* employing this monolayer culture system.

INTRAINSTITUTIONAL RELOCATION AND TERRITORIAL BEHAVIOR OF GERIATRIC RESIDENTS WITHIN SELECTED NURSING HOMES: A PILOT EXPLORATION, Barbara F. Heller, The University of Nebraska Medical Center, College of Nursing, Omaha, Nebraska.

The problems examined in this pilot exploratory study were: (1) What is the nature of the relationship between territorial behavior and functional ability of geriatric residents who undergo room changes in selected homes for the elderly? (2) Is there a variation in the dopamine- β -hydroxylase (DBH) activity of selected residents involved in room changes?

The purposes of the study were to: (1) explore and describe possible relationships between territorial behavior and functional ability of geriatric residents who undergo room changes, (2) explore and describe possible relationships between residents' ability, (3) examine and describe possible relationships between DBH activity and residents' response to territorial intrusion.

Territorial behavior was defined as conscious or unconscious behavior displayed toward a particular object or thing which is identified as part of the individual's personal identity. 17 residents (12 female and 5 males from selected nursing homes located in a midwestern metropolitan city) were purposively selected to participate in the study. 6 subjects (all female) were purposively selected to participate in the measure of a plasma constituent (DBH). Data were collected within 24 hrs. of and 2 wks. after the relocation. All residents responded to questionnaires, functional ability rating scale at 2 different time intervals. Analysis of data were done to explore relationships between territorial behavior, territorial intrusion and DBH activity.

Findings include the following: (1) 5 of the 8 residents with low territorial behavior (fewer possessions) had high anxiety toward territorial intrusion while those with high territorial behavior (more possessions) had low anxiety, (2) 4 of the 5 residents

demonstrated an percent of DBH activity, of these 1 had high anxiety and 3 had low anxiety.

THE DISTRIBUTION OF PHENYTOIN IN GUINEA PIG HEART, Richard H. Kennedy and Jean D. Deupree, The University of Nebraska Medical Center, Omaha, Nebraska.

The atrial, ventricular, ventricular septal, and subcellular distribution of phenytoin in guinea pig cardiac tissue was studied one hour after intraperitoneal injection of 20 mg/kg of ^{14}C -phenytoin (DILANTIN). There was no significant difference ($p > 0.05$) between the concentrations of phenytoin in the atria and the ventricles. Phenytoin was also equally distributed throughout the inter-ventricular septum. Subcellular distribution studies indicated no significant differences in the phenytoin concentrations among the nuclear, mitochondrial and microsomal fractions. The supernatant fraction contained a significantly higher concentration of phenytoin. These results indicated that there was a substantial degree of nonspecific phenytoin binding in cardiac tissue. Thus, the differential effects of phenytoin on atrial and ventricular arrhythmias could not be explained by differences in concentration of phenytoin in these two tissues.

AUTOIMMUNE-TYPE ENDOCRINE CHANGES FOLLOWING INFANT THYMECTOMY IN RATS, Helen L. Lipscomb, Shona Bohbrink and J. G. Sharp, University of Nebraska Medical Center, Omaha, Nebraska.

During pre- and early neonatal periods, the thymus gland processes helper T cells (T_H) which are essential for the establishment of immunological competence. Also during this period, and subsequently into adulthood, the thymus processes suppressor T cells (T_S) which perform an immunoregulatory function. It has been shown that thymectomy in mice between 2 and 5 days of age causes the development of thyroiditis and ovarian dysgenesis when the mice reach adulthood. This suggests that removal of the thymus during this period may alter the balance which exists between T_H and T_S ,

causing preferential removal of T_S and development of autoimmune disease. To investigate this phenomenon, we have compared the effects of thymectomy at day one (neonatal) versus thymectomy at day 5 (infant) in three strains of rats — Fischer 344 (F344), Holtzman (HZ), and Sprague-Dawley (SD). Animals were autopsied at 90 days of age, and the endocrine organs weighed and examined histologically. No differences in body weight were found for any of the groups, and no changes in endocrine organ weight were noted for male and female HZ or SD, and male F344 rats. However, the adrenals, thyroid, ovaries, and kidney were decreased in weight in female F344 rats thymectomized on day 5. Preliminary observations suggest that a prominent histological change occurred in the thyroid, and included lymphocytic infiltration and loss of colloid resembling the very early stages of autoimmune thyroiditis. Serum levels of thyroxine were also significantly decreased. These results suggest that infant thymectomized female F344 rats may prove to be a satisfactory animal model for some types of human autoimmune disorders. By using various strains of animals, it may be possible to enhance, by infant thymectomy, a naturally occurring, genetic predisposition towards a given autoimmune disorder. This type of model might more closely resemble human autoimmune diseases since, often experimentally induced (e.g. by immunization) autoimmune diseases bear little resemblance to their human counterpart.

METABOLITES OF POLYCYCLIC AROMATIC HYDROCARBONS: A NEW APPROACH TO PRODUCT IDENTIFICATION IN HIGH PRESSURE LIQUID CHROMATOGRAPHY, Stephen Marsh and Carter Grandjean, Eppley Institute for Research in Cancer, University of Nebraska Medical Center, Omaha, Nebraska.

Metabolite identification methods, of a more efficient type than those conventionally employed in high pressure liquid chromatography (HPLC), were needed to expedite our studies on metabolism of polycyclic aromatic hydrocarbons (PAH). Authentic standards of some known metabolites of 3-methylcholanthrene and 7-methylbenzo(a)-

anthracene were chromatographed by HPLC and the eluent was monitored for both absorbance and fluorescence. The ratio of these two parameters was then compared to that of the other compounds.

Each of the compounds studied had its characteristic ratio of fluorescence/absorption and this provided an additional parameter by which chromatograms could be better interpreted.

VARIABLES IN THE NURSING DIAGNOSIS OF IMPAIRED PARENTING RELATIVE TO THE PRESCHOOL CHILD: A PILOT EXPLORATION, Karen Martin, The University of Nebraska College of Nursing, Omaha, Nebraska.

This pilot exploratory study was designed to investigate the nature of the nursing diagnosis, impaired parenting, in selected families in the home setting. The objectives of this study were to delineate signs and symptoms of this diagnosis, describe the frequency of occurrence and degree of severity of each sign and symptom, and examine possible relationships between the diagnosis and the demographic variables of age and significant others.

The sample consisted of ten subjects, each the parent of a preschool child. The subjects were currently receiving nursing care from a community health agency in a large mid-western city.

The methodology included an observation tool and interview guide. Data were analyzed and results were presented in narrative and table format.

The major conclusions derived from this study included (1) The nursing diagnosis, impaired parenting, is defined by fifteen signs and symptoms; is identified both by signs and symptoms; and is categorized by development, socialization, and health, accidents, injuries, and illness (2) Signs and symptoms involving socialization dominate the diagnosis (3) The interaction of agent, host, and environment produces the diagnosis. Conclusions were also derived relevant to frequency of occurrence and degree of severity of each sign and symptom as well as the selected demographic variables.

It is suggested that the community health nurse (1) Utilize the signs and symptoms reported to assess actual and potential problems of parenting (2) Develop inter-ventive strategies in order that diagnostic-specific interventions and predicted outcomes result.

Recommendations for further research were elaborated.

VARIABLES IN THE NURSING DIAGNOSIS OF THE FAILURE TO ACCOMPLISH DEVELOPMENTAL TASKS OF PREGNANCY DURING ADOLESCENCE: A PILOT EXPLORATION, Nancy Mockelstrom, University of Nebraska College of Nursing, Omaha, Nebraska.

This pilot exploratory study was designed to investigate the nature of the nursing diagnosis, failure to accomplish developmental tasks of pregnancy during adolescence, in selected families in the home setting. More particularly, the objectives of this study were to: delineate signs and symptoms of this nursing diagnosis, describe the frequency of occurrence and the degree of severity of each sign and symptom, and examine possible relationships between this diagnosis and selected demographic variables.

The sample consisted of eight subjects currently receiving community health nursing care from an agency in a midwestern metropolitan area. The methodology included observation and an interview tool. The number and kinds of signs and symptoms were analyzed for similarities and differences and results were presented in narrative and table format.

The major conclusions derived from this study included (1) the nursing diagnosis, failure to accomplish developmental tasks of pregnancy during adolescence, is defined by nine signs and symptoms; (2) the psychosocial aspects of the developmental tasks of pregnancy dominate the nursing diagnosis; (3) the interaction of agent, host, and environment produces this nursing diagnosis, however, the majority of signs and symptoms relate to host factors. Conclusions were also derived relevant to frequency of occurrence and degree of severity of each sign and

symptom as well as the selected demographic variables.

It is suggested that the community health nurse (1) utilize the signs and symptoms reported to assess actual and potential problems of adolescent pregnancy (2) develop intervention strategies that result in diagnostic specific interventions and predicted outcomes.

STUDIES ON ISOPROTERENOL-INDUCED CARDIOMYOPATHY IN RATS, Athari-Nejad, A., Holsclaw, T.L., Ryan, C.F., The University of Nebraska Medical Center, Omaha, NE.

The role of beta adrenergic receptor activation in isoproterenol-induced cardiomyopathy was studied. Cardiomyopathy induced by isoproterenol can be quantitated by determining the amount of binding of ^3H tetracycline (50 uCi/kg, s.c. 3 hrs. before sacrifice) to myocardial tissue. Radioactively-labeled tetracycline has been shown to bind selectively to necrotic tissue and forms the basis for the quantitative analysis of sympathomimetic-induced myocardial damage. The degree of binding of tetracycline was directly proportional to the degree of myocardial damage, which in turn is directly proportional to the log dose of isoproterenol. To conform the role of beta adrenergic activation, both (+) and (−) isomers of isoproterenol were employed. The (−) isomer induced three to four times more injury than the (+) isomer. Our studies also show that the beta blocking agent, propranolol, diminished myocardial damage by isoproterenol. Studies by other investigators showed an elevation of cAMP which suggests a possible involvement of cAMP in isoproterenol-induced cardiomyopathy. Aminophylline (95 mg/kg s.c.), did not produce any cardiomyopathy as measured with this method. However, aminophylline potentiated isoproterenol-induced cardiomyopathy. This study strongly suggests that beta adrenergic receptors are involved in cardiomyopathy induced with isoproterenol in rats. Furthermore, the effect elicited by aminophylline, combined with isoproterenol compared to isoproterenol alone, indicates a possible involvement of cAMP in cardiomyopathy. However, subcutaneous doses of 10 mg/kg and

100 mg/kg dibutyryl cAMP did not produce significant cardiomyopathy.

ECOLOGICAL ATTACHMENT IN INTRA-INSTITUTIONAL RELOCATION AMONG THE ELDERLY IN SELECTED NURSING HOMES: A PILOT EXPLORATION, Geraldine Newton, College of Nursing, University of Nebraska, Omaha, Nebraska.

This pilot exploratory study was designed to investigate the following questions: (1) What is the variation, if any, of functional ability associated with intra-institutional relocation (room changes) of geriatric residents, (2) Will the level of dopamine-beta-hydroxylase (DBH) activity support the level of functional ability related to room change, and (3) What are the possible sources of stress in ecological detachment?

Seventeen elderly subjects were purposively selected from five nursing care facilities to be assessed for functional ability at the time of the room change and during two weeks following room change by means of a structured interview. Six of the seventeen subjects were purposively selected to be tested for the level of DBH activity by means of a finger stick blood sample. Blood samples were assayed using the method of Weinshilboum and Axelrod (1971). Other measures of stress related to functional ability were the Digit Span (Wechsler, 1955), the Mental Status Questionnaire (MSQ) (Kahn et al., 1960), and the Paracheck Geriatric Behavior Rating Scale (PSBRS) (Miller and Paracheck, 1974).

While the PSBRS was not sensitive in this short time, according to the observer's notations, pathophysiological symptoms appeared to increase. Two of five subjects responded with increases in the level of DBH activity and three subjects responded in the opposite direction. Although the small sample size did not merit any sophisticated statistical procedure, the trends in graphs indicated there might be a significant relationship between the level of DBH activity and the measures of functional ability. Possible sources of stress were associated with age, sex, marital status, length of residence, advance notice of the move, who

informed the subject of the move, and the involuntary nature of the move.

Implications for nursing care and future research were proposed.

THE STRUCTURE OF THE NORMAL PANCREAS IN THE SYRIAN GOLDEN HAMSTER [MESOCRICETUS AURATUS WATERHOUSE] — SCANNING ELECTRONMICROSCOPIC [SEM] OBSERVATIONS, Doris Ogrowsky and J. Althoff, Eppley Institute for Research in Cancer, University of Nebraska Medical Center, Omaha, NE.

The Syrian hamster provides the only available animal model for the study of chemical carcinogenesis of pancreas neoplasms originating in the duct epithelium. The morphology of these tumors was reportedly similar to those found in man. Because little is known about the normal structure of the hamster pancreas, SEM examinations were initiated, since SEM has the advantage of showing the luminal surface of the ductal system.

The islets of Langerhans are not seen in the pancreas at day 15 of gestation or shortly after delivery; they develop within the next 14 postnatal days and double their size by the end of the lactation period (day 28 after birth). In hamsters more than one year old, the islets of Langerhans reach a length of approximately 300 μ m.

Acini in the fetal pancreas show a glandular structure, and their cells already contain zymogen granules. The final size of the pancreatic acini (37 x 26 μ m) is reached by the end of the lactation period.

The age of the animal does not markedly affect the epithelial height of the pancreatic ducts. Small ducts are lined by a cuboidal epithelium, whereas large ducts show a columnar epithelial lining. The type of epithelium correlates with the luminal size, which increases with progressing age. The luminal surface of the ductal epithelium (small and large ducts) shows varying forms and density of microvilli, and usually a single and centrally located cilium (flagellum). Mucus-producing cells are identified by droplets or conglomerates which protrude onto

the cell surface; this cell type begins to occur in the common duct of 4-week-old hamsters and is prominent in adult animals. The present investigations have shown that SEM provides an appropriate method to study ultrastructural aspects of pancreatic surface patterns (natural and cut surfaces).

ACTIVITY PATTERNS, DIETARY HABITS, PERCEIVED STRESS, AND OCCUPATIONAL AND/OR ENVIRONMENTAL STRESS OF HYPERTENSIVE CLIENTS, A PILOT EXPLORATORY STUDY, Mary E. Partusch, University of Nebraska College of Nursing, Omaha, Nebraska.

This pilot study was designed to explore the activity patterns, dietary habits, response to perceived stress, occupational and/or environmental stress of the hypertensive subject in his home and work environment to determine factors present which may influence control of hypertension. Fifteen subjects under anti-hypertensive treatment were purposively selected. The individual subjects' homes were utilized for data collection. Instruments included a Subject Data Base, an Interview Schedule, A Holm's Scale for Rating Life Changes, an Activity Record and a Dietary Record.

Six of the fifteen subjects had blood pressures above 140/90. Seven of eleven subjects reporting work activities which contained physical activity had blood pressures controlled under 140/90. Five of fourteen subjects reporting sedentary leisure activities had a blood pressure over 140/90. Using a Spearman Rank Correlation Coefficient, a negative correlation was found between dietary sodium and blood pressure, and weight and blood pressure and a positive correlation between dietary fat and blood pressure. Eleven subjects scored low, three in the middle, and one scored high on the Holme's Scale For Rating Life Changes.

Daily exercise and a low fat diet may help to control blood pressure. The negative correlations between dietary sodium and blood pressure, and weight and blood pres-

sure may be due to use of a blood pressure under treatment rather a pre-treatment baseline blood pressure. The Holme's Scale For Rating Life Changes was not effective in uncovering stress in this sample population.

THE VALUE OF SPECIFIC NURSING ASSESSMENTS AS A PREDICTOR OF HYPERTENSION IN THE PRIMIGRAVIDA: A PILOT EXPLORATORY STUDY, Judith Kielty Quinn, University of Nebraska College of Nursing.

This study was designed to consider what are the potential values of specific nursing assessments in the early detection of hypertension in the primigravida in her mid-second trimester of pregnancy. Tools and measurements used in this research were: the Holmes Social Readjustment Scale, to investigate the influence of stress; a three day dietary diary to determine protein and calorie intake; a family history for incidence of hypertension; the roll-over (Gant Test) to delineate which subject is prone to develop pre-eclampsia was administered at each clinic visit between the 26th and the 32nd week of pregnancy; a modified Allison scale to explore the meaning of rest to the individual.

Results of this limited study showed that subjects having a positive Gant Test did develop hypertension and those with a negative test did not. The subjects with a high stress in the Holmes scale did not develop hypertension, two with lower stress did have subsequent hypertension. Of six subjects with a family history of hypertension, two developed hypertension. The nutritional surveys indicate all subjects but one were consistently low on both calories and protein. The meaning of rest varied for all subjects but sleep was seen by all but one as being restful.

The nurse in the clinic can perform certain assessments to predict who will be at risk to develop toxemia. Evaluating the family history and administering the Gant test may help predict those at risk. Having the same nurse see the patients at each clinic visit will enable her to continually evaluate the patient and interpret the nursing assessments.

COMPARISON OF PARENTING TECHNIQUES FOR INCREASING COMPLIANCE IN A YOUNG OPPOSITIONAL CHILD, Linda Riner and Karen Budd, The University of Nebraska Medical Center, Omaha, Nebraska.

Previous research has shown that parents can be taught to apply behavior modification procedures in order to improve their own children's behavior. However, few studies have evaluated the relative effectiveness of various child management techniques. The present study compared the effectiveness of two set of procedures for helping a young mother increase compliance in her young son. This evaluation was conducted during weekly observations of mother-child interactions in the family's home. The first child management package (Treatment I) consisted of having the mother physically guide the child, when necessary, to obtain compliance, and to provide praise when the child followed instructions independently. The second package (Treatment II) included the above components plus providing the child access to preferred activities when he complied quickly and independently. A single-subject reversal design was used to compare the effectiveness of the procedures. In this design, the two treatment packages were alternated for several sessions each, resulting in five experimental conditions: Baseline (the initial rate of compliance before treatment), Treatment I, Treatment II, reversal to Treatment I, and reinstatement to Treatment II. Throughout the experiment, continuous records of target behaviors (child compliance and parenting procedures) were kept during every session, and the reliability of the records was calculated using the simultaneous recordings of an independent observer. The mother was trained in child management techniques through instructions, practice, and feedback from the experimenter. The following results are the mean percentage of child compliance during each experimental condition: Baseline, 14%; Treatment I, 20%; Treatment II, 67%; reversal to Treatment I, 30%; and reinstatement of Treatment II, 75%. The use of praise and physical guidance (Treatment I) was not sufficient to teach this young child independent compliance. When the additional

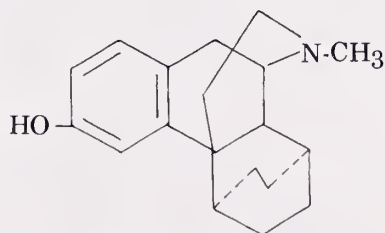
procedures of Treatment II were used, compliance increased significantly.

SYNTHESIS OF SOME BRIDGED DERIVATIVES OF MORPHINAN, Victoria F. Roche, Edward B. Roche, Sidney J. Stohs, The University of Nebraska College of Pharmacy, Omaha, Nebraska.

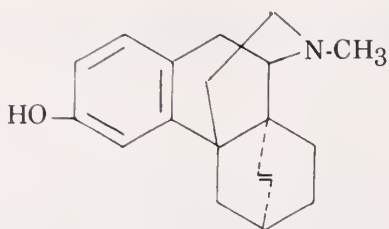
In order to further investigate the effect on analgesic potency of the endoetheno bridge in the C ring of the rigid narcotic etorphine, syntheses have been designed to incorporate this linkage in the more flexible analgesic molecule, morphinan.

Two synthetic pathways are currently being carried out to prepare both 6,14-endoetheno and 5,8-endoathano-3-hydroxy-N-methyl morphinan, utilizing 7-methoxy-1-tetralone and bicyclo (2.2.2.)-2-octene, respectively, as starting materials. Following a documented organic reaction procedures, 2-spiro (3-hydroxypentane)-1-cyanomethyl-1-hydroxy-7-methoxy-1,2,3,4-tetrahydronaphthalene and bicyclo (2.2.2.)-2-2-(p-methoxyphenylacetamido)ethyl)-2-octanyl p-methoxyphenyl-acetate have been synthesized as intermediates to the final bridged morphinan derivatives. The structures of all reaction intermediates synthesized thus far have been characterized through nuclear magnetic resonance and infrared spectrophotometric analyses.

In conclusion, the synthetic schemes designed appear to be feasible pathways to the desired bridged morphinan systems and allow for the isolation of reaction intermediates in sizable yields.



5,8-endothano-3-hydroxy-N-methyl morphinan



6,14-endoetheno-3-hydroxy-N-methyl morphinan

VARIABLES IN THE NURSING DIAGNOSIS OF MID-CHILDHOOD DEPRESSION: A PILOT EXPLORATION, Dorothy Kiku Sato-Stoll.

This study was designed to investigate the nature of the nursing diagnosis, midchildhood depression, in selected families in the home setting. The objectives of this study were to delineate signs and symptoms of this nursing diagnosis, describe the frequency of occurrence and the degree of severity of each sign and symptom, and examine the possible relationships between the demographic variables of age, sex, sibling order, family structure, and history of situational disturbance with this nursing diagnosis.

The sample consisted of twelve subjects, five to ten years of age, who were currently receiving community health nursing service from an agency in a midwestern, metropolitan area. The methodology included an observation tool and an interview guide. Data were analyzed and results presented in narrative and table format.

The major conclusions derived include: (1) the nursing diagnosis, midchildhood depression, is identified by twenty signs and symptoms; (2) the signs and symptoms are almost equally expressed as masked depressive equivalents, unique to children, and manifestations similar to those observed in adult depression; (3) the agent, host, and environment dynamically interact to produce this diagnosis. Conclusions were also derived relevant to frequency of occurrence and degree of severity, as well as the selected demographic variables. It is suggested that the community health nurse: (1) utilize the signs and symptoms reported to assess and

identify depressed and potentially depressed children; (2) develop diagnostic-specific interventive strategies therapeutic to mid-childhood depression. Recommendations for further research were elaborated.

ESTABLISHMENT OF PREOPERATIVE BASELINE VITAL SIGNS: A PILOT EXPLORATORY STUDY, Mary Jo Schulte, The University of Nebraska Medical Center, Omaha, Nebraska.

The purposes of the study were to (1) explore the differences between vital signs measured in the immediate preoperative period and a baseline of four sets of vital signs and (2) look at possible relationships of differences to patient factors of age, sex, previous surgery, and type of surgery.

A mean of four sets of vital signs taken the evening before and early the morning of surgery was used as the established baseline for each of the twenty subjects. Vital signs were then measured immediately before the preoperative medication was administered and these were compared to the baseline means for differences and analyzed according to the four factors mentioned earlier.

The following results and conclusions were reached: (1) oral temperature and pulse readings taken in the immediate preoperative period did not differ from an established baseline mean, while respiration and blood pressure readings did differ; (2) patients in the 50-65 age range showed more variation in respiratory rate than the 20-34 or 35-49 ranges, while blood pressure differed more in the 20-34 and 35-49 groups than the 50-65 age range; (3) more variations in preoperative blood pressure were seen in female subjects while males had more variations in respiratory rate; (4) the type of surgery (major or minor) had no relationship to preoperative variations from the baselines; and (5) the length of time since the last surgery had no relationship to preoperative variations in vital signs, except in the case of pulse rate, where patients who had had surgery in the last five years had more variations than those whose past surgeries were more than five years ago.

IDENTIFICATION AND QUANTITATION OF BIOGENIC AMINES BY HIGH-PERFORMANCE LIQUID CHROMATOGRAPHY WITH ELECTROCHEMICAL DETECTION, Glen A. Scratchley, Asaad N. Masoud, Daniel W. Wingard, and Sidney J. Stohs, The University of Nebraska Medical Center, Omaha, Nebraska.

High-performance liquid chromatography (HPLC) is a recently-developed analytical technique for the separation, identification and quantitation of a wide variety of compounds. Many of the presently accepted methods of measurement of catecholamines in biological fluids lack specificity and sensitivity.

The specific application of HPLC to be presented concerns the determination of catecholamines in biological samples. The four major amines of interest, norepinephrine, dopa, epinephrine, and dopamine, can be separated by ion-pair, reversed-phase HPLC. The eluted compounds can be detected and measured quantitatively on the basis of the amperage produced by the formation of oxidation products.

With the combination of HPLC and electrochemical detection the separation and individual quantitation of these four biogenic amines at endogenous levels is possible.

CREATINE PHOSPHOKINASE AND LACTATE DEHYDROGENASE ISOENZYME ACTIVITY IN TRAINED DISTANCE RUNNERS DURING PROLONGED EXERCISE, Timothy J. Stivins, William E. Boernke, and Carl R. Jolliff, Nebraska Wesleyan University, Lincoln, Nebraska.

The use of CPK and LDH isoenzyme quantitation is valid in determination of myocardial infarction, is using this approach trained distance runners are checked for myocardial damage resultant of excessive stress. The isoenzyme quantitations were both accomplished using reagent kits marketed by Beckman Instruments, Inc. The total enzyme quantitations were accomplished using reagent kits by Gilford Instruments, Inc. Although all the subjects showed increased total sera enzyme levels in the study's course, at no time did any CPK2 (MB) quantitation exceed 3% or any LDHI-

(H4) relative % exceed that of corresponding LDH2(H3M) relative %. No myocardial damage was evidenced, and it appears possible that influenza and/or apprehension can increase CPK2(MB) concentration.

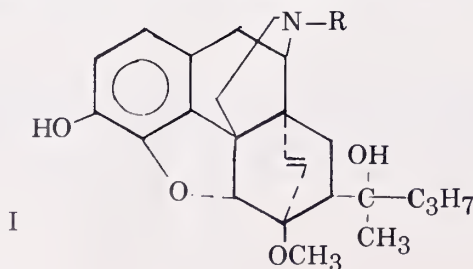
ETORPHINE DERIVATIVES AND RECEPTOR INACTIVATORS, Christie L. Wegner and Edward B. Roche, The University of Nebraska College of Pharmacy, Omaha, Nebraska.

Opium alkaloids have been used for their analgesic effects for numerous years. Though extensive research is being done with regard to analgesic receptors and mechanisms, precise receptor localization and characterization is not complete. To further characterize analgesic receptors, we are synthesizing and evaluating a series of potential irreversible receptor inactivators derived from a potent narcotic analgesic, etorphine. (I, R= CH₃)

The potency of this analgesic is expected to impart selectivity to the alkylating derivatives. Two types of derivatives are proposed: alkylating derivatives where R is maleimide and fumaramide, and a nonalkylating derivative where R is succinimide. The latter compound is designed to assess the analgesic potency relative to etorphine.

The synthesis of etorphine from a non-narcotic opium alkaloid, thebaine, has been developed and yields optimized. The intermediates in the synthesis of etorphine are: thevinone, 19-propylthevinol, N-cyano-19-propylthevinol and noretorphine. The intermediate compounds have been evaluated as to their physico-chemical properties. Nuclear magnetic resonance and infrared spectrophotometric analysis has also been carried out.

In conclusion, noretorphine has been synthesized with reasonable yields and provides the basic starting compound with which to synthesize the potential irreversible analgesic receptor alkylating agents.



SELF CONCEPT OF SELECTED BREAST FEEDING AND BOTTLE FEEDING PRIMIPARAS: A PILOT EXPLORATORY DESCRIPTIVE STUDY, Paula Lindsey Wilson, University of Nebraska College of Nursing, Omaha, Nebraska.

The purposes of this pilot study included description of the relationship of self concept to infant feeding choice and identification of self concept correlates which relate to infant feeding choices of primiparas.

Self concepts of 20 breast feeding and 20 bottle feeding primiparas were studied using a Q-Sort test designed by the student investigator. The Q-Sort consisted of 48 adjectives and generated data on four correlates of self concept: personal aspirations, anxiety, acceptance of others, and physical self. The composite score was utilized as an over-all level of self concept. A Patient Interview Schedule was used to collect data on subject's age, housing facilities, education and employment status of subject and spouse, and the planned/accidental nature of the pregnancy.

Breast feeding subjects scored more positively on personal aspirations, acceptance of others, and physical self, and more negatively on anxiety (indicating higher levels of anxiety) than did bottle feeders. Breast feeders were slightly better educated, were more likely to be employed, and less likely to have accidental pregnancies than were bottle feeders. Spouses of breast feeders were much better educated than bottle feeders' spouses.

Breast feeding primiparas had a more positive overall view of themselves than bottle feeding primiparas. Moderate to positive self concept was related to both breast feeding and bottle feeding, but negative self concept was related only to bottle feeding. Accidental pregnancy in the primipara was related to selection of bottle feeding for infant nutrition.

A PROCEDURE FOR RADIOACTIVE LABELLING OF QUINIDINE, Patrick M. Woster, The University of Nebraska College of Pharmacy, Omaha, Nebraska.

The advent of a new procedure for demethylating the 6-methoxy group on the

quinidine molecule introduces the possibility of forming ethers, and specifically to reform quinidine using a radiolabelled reagent. This cold procedure utilizes methyl iodide in a nucleophilic substitution reaction, with trial and error dictating the proper solvent and conditions. Results are checked by thin layer chromatography, and a final microscale reaction is carried out on a preparative TLC plate. Yields are determined using fluorescence.

Results indicate yields which, although low, are sufficient to prove that radiolabelling of quinidine can be accomplished by this procedure. Yields are found to be the highest in two non-protic solvents, methylformamide and methyl ethyl ketone, and in each solvent enough quinidine is formed to exhibit the feasibility of the synthesis.

In conclusion, it has been shown that this reaction occurs, and it is further postulated that the synthesis could be further adapted to bring about higher yields. This would in turn make the radiolabelling of quinidine economically feasible.

HISTORY: STUDENT RESEARCH FORUM

It was in 1974 that a group of students organized the first UNMC Student Research Forum with the help of Chancellor Robert D. Sparks and the Richard Larsen Fund.

Since then, the Forum has served as an opportunity for UNMC students to present original research in a meeting of their peers each year.

Held under the auspices of the Student Research Forum Committee, consisting of students and faculty advisors from all four UNMC colleges, the Forum also gives students a chance to win cash awards and travel and room expenses to national meetings on the basis of judging by Medical Center faculty.

Throughout the years, the Forum has featured outstanding keynote speakers, including:

1974 — John A. D. Cooper, M.D., President, American Association of Medical Colleges

1975 — Warren Pearse, M.D., Executive Director, American College of Obstetrics and Gynecology

1976 — Arthur C. Guyton, M.D., Chairman, Department of Physiology and Bio-

physics, University of Mississippi Medical Center

This year's speaker was Hubert Ritter, M.D., President, American Medical Association's Education and Research Foundation.

Cartilaginous Tumors of the Larynx

SUMMARY

Two chondromas and one chondrosarcoma are added to the 150 chondromas and 28 chondrosarcomas of the larynx which have been reported in the literature.

Symptoms and signs include changes in the voice, dyspnea, dysphagia, and the presence of a mass in the neck.

Chondromas and chondrosarcomas are blue-gray, well circumscribed often lobulated masses of hyaline cartilage which may contain mucinous cysts as well as areas of calcification or ossification.

Histologic criteria for malignancy comprise: 1) many cells with plump nuclei, 2) more than an occasional cell with two such nuclei, and 3) giant cartilage cells with large single or multiple nuclei or with clumps of chromatin. Histologic and clinical malignancy need not coincide.

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Treatment of cartilaginous laryngeal tumors is conservative and consists of local excision, although in some cases total laryngectomy is necessary.

THIS paper is based upon three patients with cartilaginous tumors of the larynx.

The first patient was a 28 year old male with a 5x3x3 cm multinodular cartilaginous mass (Fig. 1) which originated from the cricoid cartilage. The final pathologic diagnosis was chondroma of the cricoid cartilage. This patient was the youngest reported case of laryngeal chondroma.



Fig. 1 — Medium power view of specimen from case # 1 showing small cartilage cells, mostly with only one small nucleus. No multinucleated giant cells are seen.

The second patient was a 61 year old male who entered the hospital short of breath with a weak voice. Twenty years prior to admission he had had local excision of a lesion of the larynx which had also caused him to be short of breath. The larynx was symmetrically enlarged and the vocal cords paralyzed. X-rays revealed a large subglottic mass containing calcifications, a compressed esophagus, and a severely narrowed air column. Biopsy revealed chondroma. A total laryngectomy was done and the specimen

was a 6x7 cm tumor originating from the right thyroid lamina which nearly completely filled the subglottic larynx. The pathologic diagnosis was chondroma of the thyroid cartilage. Origin from the thyroid cartilage, huge size, and apparent recurrence after 20 years are unusual features of this case.

The third case was a 77 year old male admitted with stridor and with a 2 cm. mass bulging from the cricoid cartilage. The right true cord was paralyzed. X-rays revealed the mass to partially occlude the subglottic

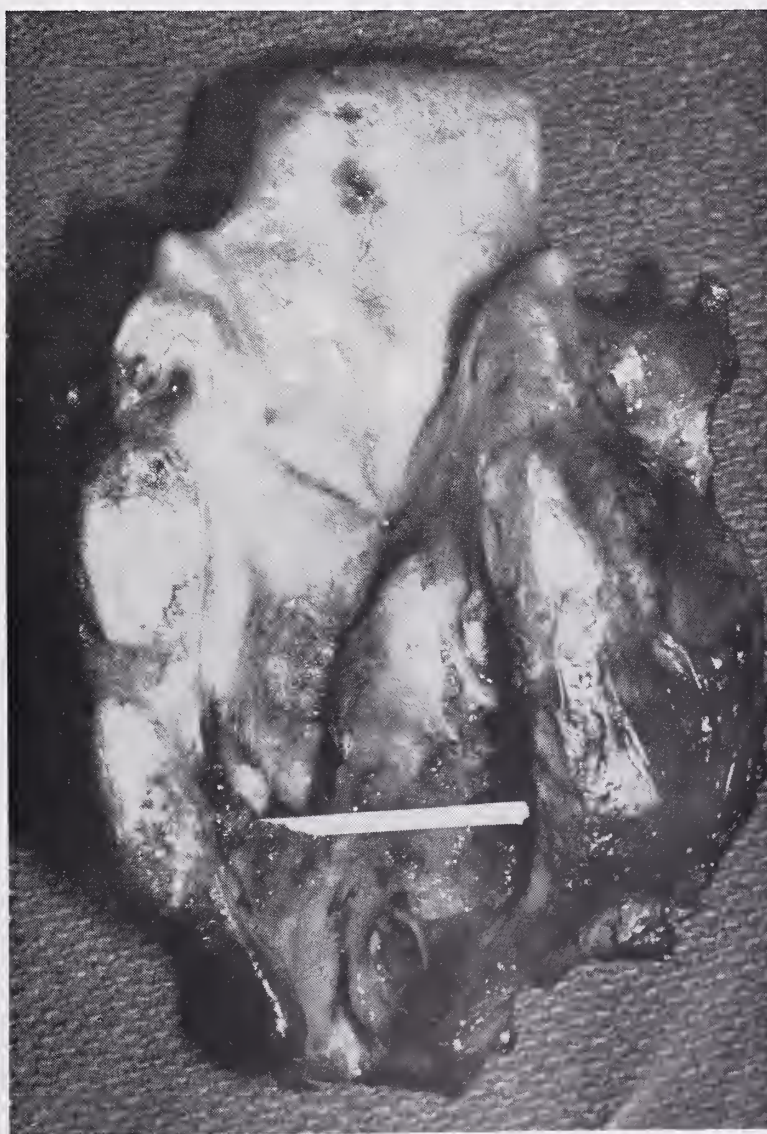


Fig. 2 — Larynx opened from behind. Tumor massively involves the right thyroid lamina. An area of ulceration due to pressure of the mass against the left subglottic area is visible.

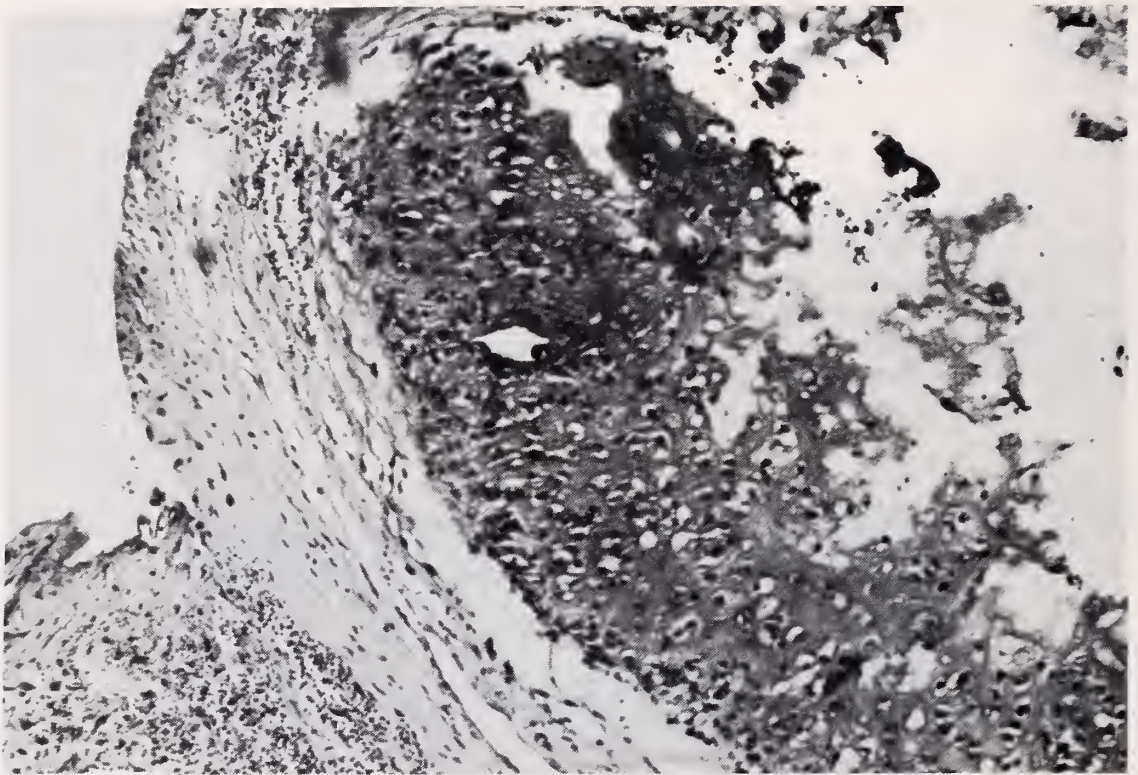


Fig. 3 — Low power view of chondrosarcoma.

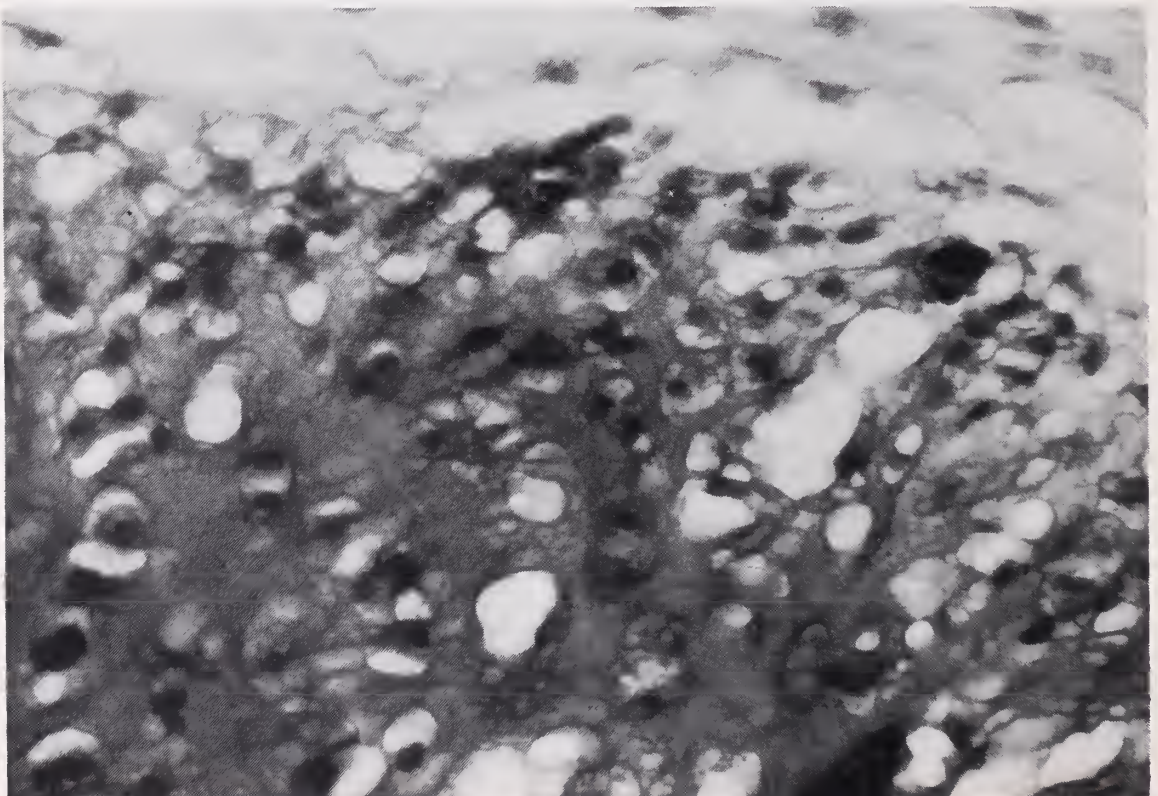


Fig. 4 — High power view of chondrosarcoma.

airway. Biopsy revealed chondrosarcoma (Figs 3, 4). A total laryngectomy was performed. This is the 29th chondrosarcoma of the larynx to be reported.

Discussion

Approximately 150 cartilaginous tumors of the larynx have been reported since Heusinger first described a case in 1822. The ages of these patients have varied from 34 to 91, but most have been males in their fifties and sixties. 90% of the tumors arise from the cricoid cartilage, especially its lamina, and most of the rest arise from the thyroid cartilage. A few cases arising from the epiglottis and arytenoid cartilages have been reported. The tumors vary in size from millimeters to seven centimeters in diameter. 80% have been benign chondromas, and 20% chondrosarcomas. Through 1963 only six cases of laryngeal chondrosarcoma had been recorded in the American Registry of Otolaryngic Pathology, Armed Forces Institute of Pathology, out of a total of 4,700 malignant laryngeal tumors.

Changes in the voice and dyspnea are present if the tumor grows into the laryngeal lumen or impairs vocal cord function. Extraluminal growth results in dysphagia or presents as a mass in the neck. In patients with intraluminal tumors, there is usually seen a subglottic mass and one or both vocal cords may be immobilized.

Attempts at intralaryngeal biopsy often produce only a piece of mucosa, because the surface of the lesion is frequently very hard.

Useful x-ray studies include a laryngogram, laminograms of the larynx, esophagram and planograms.

Chondromas of the larynx are benign but tend to recur following local excision. Brandenburg et al¹ state that "chondrosarcomas will usually metastasize late, spreading by vascular invasion eventually to reach the heart and lungs. There have been no reported instances of laryngeal chondrosarcoma metastasizing to regional lymph nodes."

Grossly, the tumors are blue-gray, often lobulated, well circumscribed masses of hyaline cartilage which may contain mucinous cysts, areas of calcification or ossification. All reported cases of laryngeal chondrosarcoma, a total of 28, have been reported since 1943, when Lichtenstein and Jaffe clarified the histologic criteria for differentiation of chondromas from chondrosarcomas. Their criteria for malignancy comprise: 1) many cells with plump nuclei, 2) more than an occasional cell with two such nuclei, and 3) giant cartilage cells with large single or multiple nuclei or with clumps of chromatin.

Histological and clinical malignancy need not coincide. Geothals et al² reported 22 cases of cartilaginous laryngeal tumors from the files of the Mayo Clinic. 18 of these were histologically chondrosarcomas, yet none of them metastasized and only 6 gave rise to local recurrences.

Treatment of cartilaginous laryngeal tumors is conservative and consists of local excision, although bulky tumors may require total laryngectomy.

The patients reported in this article were from the Ohio State University Hospital.

References may be obtained from the author.

Pediatric Hernias: Indications for Surgery

PART I

CONGENITAL INGUINAL HERNIA

OTHER than adenotonsillectomy and circumcision, the most frequently performed operation in the pediatric age group is that for congenital indirect inguinal hernia. Males are affected with these hernias 9 times as often as females. A positive family history, twinning, prematurity, and cryptorchism, also are associated with increased incidence.^{10,11} The right side is involved twice as often as the left, and the hernias are bilateral in about 15.8%.²⁶ While the content of these hernias may be any intraabdominal viscus, they are often sliders, and in girls the hernia not infrequently contains the fallopian tube and ovary.

The treatment of choice of the congenital inguinal hernia is surgical. This is done electively as soon as it can conveniently be scheduled to avoid the risk of incarceration. Routinely, we operate on children under 4 years of age as day patients. Serious underlying systemic disease, such as severe congenital heart disease, may on occasion require postponement of surgery. Prematurity provides a relative contraindication, and some surgeons prefer to wait until a child is 6 weeks old or weighs 6 lbs.

The operative technique varies. Some surgeons use the Mitchell Banks technique, performing high ligation of the sac without opening the external oblique fascia. In America, the preference of most surgeons, however, is to open the external oblique fascia to obtain a more adequate high ligation of the sac, with or without a modification of Ferguson's technique. In some selected cases, an internal ring repair may be performed by placing a few sutures in the transversalis fascia. In spite of differences of technique, the recurrence rate of pediatric inguinal hernias, in skilled hands, appears to be very low.

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Incarceration is a real hazard in congenital inguinal hernia, particularly in the very young infant. In some series, 70% of children with incarceration are less than 1 year of age.^{24,25}

Treatment of incarceration should first be conservative. When a child presents with an incarcerated hernia, an attempt should be made to reduce it by quieting or sedating the child and placing him supine with the shoulders lower than the pelvis. This maneuver, sometimes aided by gentle taxis permits gravity to pull the contents of the hernia back into the abdominal cavity. The safe time allowable before permanent damage is done to contents of the sac, can only be guessed. We have arbitrarily selected 4 hours after onset of incarceration as the maximum length of time before the patient is operated upon for reduction of the hernia and repair. In our experience, about half of our patients seem to spontaneously reduce their hernia by the time they arrive at the emergency room. Of those remaining, approximately half of these will have their incarceration reduced by conservative measures. The remaining patients, roughly 25%, will require operative reduction.

The complication rate in those patients requiring operation for incarceration has been estimated at 22%, which compares unfavorably with the 0.6% rate attributed to electively repaired hernias.²⁴ This fact underscores the high desirability of operating on infants before they suffer incarceration, and also suggests that ideally it is preferable to reduce the hernia by non-operative methods and then wait several

hours for the subsidence of edema before operating. The principal complication of incarcerated inguinal hernia in our experience is infarction of the gonad with varying degrees of subsequent atrophy, although strangulation of bowel and recurrent hernia may also occur.

The Second Side — A Dilemma

Congenital inguinal hernia develops from the processus vaginalis which fails to obliterate. In 1955, Rothenberg and Barnett noted that the majority of infants and children presenting with a unilateral inguinal hernia had a persistent patent processus vaginalis on the opposite side.²³ These authors therefore recommended routine bilateral exploration of the groin in pediatric patients, and thus began a debate which has persisted for the past 20 years.

Many have questioned the reported high incidence of positive explorations, asking what constitutes a significant processus vaginalis? It is clear that if 60% of infants have a contralateral patent processus vaginalis, yet only 15.8% of the general population develop bilateral clinical hernias, that many patent processes close between childhood and adult life.^{24,26}

In dealing with the dilemma of the second side, it appears that the surgeon has two options:

1. He can ignore the question of the contralateral side, if there is not definite evidence of a hernia.
2. He can attempt to diagnose the presence of a significant contralateral patent processus, and repair it.

Many thoughtful surgeons have opted for the former, choosing to repair the unilateral hernia, and wait for the second hernia to declare itself.²⁰

Considerable controversy exists among those surgeons who take the second option, regarding the best way to go about making the diagnosis of inguinal hernia on the second side. The most direct way to diagnose the contralateral hernia or potential hernia is by surgical exploration at the time of repair of the presenting hernia. The advantages are that it avoids a possible second operation, eliminates the additive risk of a second anesthetic and reduces cost.⁹ The

disadvantages are that this approach results in many unnecessary operations, prolonged anesthesia, and the patient is exposed to the possibility of damage to vas or testis. Additionally, direct inguinal hernia has followed inadvertent damage to the posterior inguinal wall in the search for a patent processus vaginalis. Rowe and Clatworthy have concluded that it is reasonable to perform the contralateral groin explorations, but only if the following criteria are met:

1. The surgeon is skilled and experienced in the operation to correct pediatric hernia.
2. The anesthesiologist is expert in administering anesthesia to infants and children, and has available the proper equipment.
3. The patient has no serious underlying condition to increase the risk of operation.
4. The operative procedure progresses smoothly, requiring less than 1 hour total anesthesia time.²⁴

Another method to diagnose an occult hernia on the second side, is the use of transperitoneal probing.¹⁴ In the repair of the presenting hernia, the sac is opened and through it a Bake's #5 dilator is carefully passed across the abdomen, to probe the opposite processus vaginalis. Levy reported positive results in 39 of 80 cases in which the procedure was used.¹⁷ The method has not received wide acceptance, however.

The most recently developed technique, namely that of herniography, has stimulated a great deal of interest.⁹ This method involves the injection of diatrizoate sodium into the peritoneal cavity, allowing a few minutes in the erect position for the dye to settle into the lower abdomen, and then obtaining a roentgenogram which shows the dye in the patent processus. Guttman and DuCharme have shown the method to have a high degree of accuracy, demonstrating a significant contralateral sac in 22.9% patients. They have observed no major complications, although some infants have shown a shock-like state after instillation of the dye, due to its hydrophilic effect. The authors recommend that patients be very well hydrated prior to injection. Minor complications have consisted of pain and sweating. This

technique appears to be growing in popularity, but there may be some points of concern:

1. The attendant pain and discomfort.
2. The potential for injury from the needle injection of the dye.
3. Cost.
4. Radiation to gonads, even though the latter is only 80-120 milliroentgens.^{9, 29}

FEMORAL AND DIRECT INGUINAL HERNIAS

Femoral and direct inguinal hernias in childhood are extremely rare. In a review of 5,452 pediatric hernias, Fonkalsrud et al could find only 12 femoral and 13 direct inguinal hernias.

In patients with femoral hernias, no difference in incidence was noted by side or sex. There were two patients in that series who presented with incarceration. One patient was only 6 weeks of age, and presented with bilateral hernias.

Direct hernias were found much more frequently on the right and more frequently in boys. One third of the patients with direct hernia had been previously operated upon for indirect inguinal hernia, suggesting either the possibility that the posterior inguinal wall was inadvertently damaged in the previous repair, or that a concomitant congenital weakness of the transversalis fascia may have existed. The fact that in the combined series only 8 of the 25 patients had a correct preoperative diagnosis underscores that the diagnosis of the femoral or direct inguinal hernia is seldom considered in the pediatric age group.

Treatment of these hernias in the pediatric patient is the same as in adults. A surgical procedure consisting of sac inversion and repair of the transversalis fascia is required in the repair of the direct inguinal hernia. High ligation or inversion of the sac, together with transversalis fascia/Coopers ligament repair is required in femoral hernias.

UMBILICAL HERNIA

The umbilical hernia in infants and young children is a common defect, caused by incomplete closure of the fascia of the umbilical ring through which intraabdominal

organs may protrude. Umbilical hernias are thought to be more common in infants with a large cord. In this connection, obstetricians should be careful in tying off the large cord as the inadvertent clamping off of a knuckle of bowel has been observed in our hospital and also reported by others.²⁸

Prematurity increases the incidence of umbilical hernias, and a definite familial tendency has been observed. The umbilical hernia is particularly common in the black population, as high as 26.8%. There is an equal sex distribution in children, as opposed to adults.¹⁶

The natural history of umbilical hernias has been of interest. There is general agreement that the majority tend to close spontaneously, although it is presumed that some persist into adulthood. The relative significance of infantile umbilical hernias as an etiological factor in development of adult umbilical hernia is not completely clear.

Recommended treatment varies considerably. It is generally conceded that coins, trusses, and tape have no role in the treatment of umbilical hernias. They do not appear to hasten the spontaneous closure.

The question of which, if any, umbilical hernias should be surgically repaired remains an open one. Haller et al have suggested that umbilical hernia defects larger than 1.5 cm. in diameter seldom close spontaneously and recommend that such should be repaired in girls over the age of 2 years, and in all children over age 4 years.¹⁰ Incarceration of umbilical hernias has been thought to be quite rare in children, although it is well recognized as a serious complication in adults. To their surprise, Lasseletta et al found in a recent review of 590 children with umbilical hernia that 5.1% suffered either incarceration, strangulation, or evisceration through the hernia.¹⁶ They also observed that hernias of less than 1.5 cm diameter were more likely to incarcerate than those which were larger. These authors differ somewhat from Haller et al, and recommend that umbilical hernias which incarcerate before the age of 4 years should be repaired, as should any with a diameter greater than 1.5 cm which present beyond age 4 years.

The author's practice has been to repair all those which have incarcerated, and many of those still present at age 4 years. Some are watched for closure to age 7 or 9 years. An occasional hernia is repaired before age 4 years when it is very large and on repeated

observations has shown no tendency to close. Many parents exhibit anxiety about the presence of the hernia, but with reassurance most can be persuaded to wait for an appropriate length of time before demanding repair.

The Sick Sinus Syndrome

THE term "sick sinus syndrome" (SSS) was coined by Lown¹ in 1967 to describe "chaotic atrial activity with continual changes in P wave contour, with bradycardia interspersed with multiple and recurring ectopic beats with runs of atrial or nodal tachycardia." He noted the inability of the sinoatrial node in patients with chronic atrial fibrillation to resume normal pacemaker function without defibrillation. Ferrer² expanded the spectrum of atrial disease in this syndrome in 1968 to include 1) persistent, severe, and unexpected sinus bradycardia, 2) cessation of sinus rhythm for either very short, or for longer periods with replacement of this rhythm by an ectopic atrial or junctional tissue rhythm, 3) long periods of sinus arrest without a new pacemaker arising with resulting periods of cardiac arrest, 4) chronic atrial fibrillation often accompanied by slow ventricular rate, the latter not produced by drug therapy, 5) inability of the heart to resume sinus rhythm following electroversion for chronic atrial fibrillation, 6) episodes of SA node exit block not related to drug therapy. Other authors include the bradycardia-tachycardia syndrome (bouts of alternating bradycardia-tachycardia unrelating to exercise or drug therapy).

We will briefly review the etiology, clinical findings, diagnosis, treatment, and prognosis for the individual with the sick sinus syndrome.

Etiology

The sinoatrial node is a small group of cells located at the junction of the right atrium and superior vena cava. Three cell types are found within the node: the pacemaker of P cells, transitional cells, and functional atrial myocardium. The impulses

from the P cells conduct through the transitional cells to the functioning atrial myocardium. Although more than one pacemaker group will usually be active in the SA node, the group with the fastest rate will determine overall cardiac rate. A change in the sinus rate is now believed to come from suppression of one pacemaker site and the new dominance of another rather than from a change in rate of the original site. The nodal blood supply consists of the sinus node artery running through the center of the node. This artery arises from the right coronary artery 55-60% of the time and from the left circumflex 40-45%. Thus SA node dysfunction may arise due to impulse transmission problems with the transitional cells (exit block) or secondary to a decreased blood supply (as in coronary artery disease).

Coronary artery disease (CAD) or ischemic heart disease is the most common single disease described for the etiology of the SSS. Rubenstein et al³ discussed 56 patients with SSS, of which 20 had CAD; but another 25 had no clear etiology. Conde et al⁴ examined 31 patients with SSS and found 15 to have evidence of CAD, but eight of the group had no diagnosed clinical abnormality other than SSS. Wan et al⁵ examined 15 cases, of which five had evidence of CAD and two had unknown etiologies. Kaplan et al⁶ described 10 patients with SSS, of which six

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had CAD and the other four had undetermined etiologies. Thus, of the 112 patients described, 41 (37%) had evidence (historically or by EKG) of CAD, while 39 (35%) had no identifiable cause. Other diseases which have been described in association with SSS are listed in Table 1. An uncommon, but increasing cause stems from cardiac surgery. Injury to the SA node occurs from cannulation of the superior vena cava near the node.

In association with CAD, sinus node dysfunction occurs in 5% of acute myocardial infarctions.⁶ SA node infarction usually occurs with right coronary occlusion (50% of inferior MIs have SA node dysfunction), or left circumflex occlusion (anterolateral MI); but rarely with left anterior descending occlusion (anteroseptal MI). These can be explained by the origin of the sinus node artery.

However, the involvement of the sinus node artery with CAD will not always produce SA nodal dysfunction; and conversely, SA nodal dysfunction does not always mean CAD either as noted earlier. Engel et al⁷ recently showed by coronary angiography that, of 80 patients with CAD, 21% had disease of or proximal to the nodal artery, but none of these had SSS. On the other hand, six patients with SSS showed no evidence of nodal artery disease.

Clinical Findings

Clinically, SSS-induced arrhythmias produce transient hypoperfusion of vital structures, e.g., the brain. This will commonly lead to complaints of syncope, dizziness, palpitations, and fatigue or weakness. Others have described heart failure, angina (during a tachycardia), dyspnea, edema, and stroke^{3,4,8,9,10} Often there are multiple presenting complaints. Age usually correlates with etiology, younger age groups (less than forty years) having noncardiovascular causes, while the older age group usually has underlying cardiovascular disease.

Any one of a number of arrhythmias can be associated with the SSS. Table 2 shows the various arrhythmias and their numbers noted in 212 patients reported in several studies.^{3, 4, 8, 9, 12} Sinus bradycardia presents most often, usually at a rate between thirty and fifty. Supraventricular tachycardia is next, often combined with sinus bradycardia to give the bradycardia-tachycardia syndrome. Obviously more than one arrhythmia can occur in any one patient.

Other EKG findings in this same group include conduction disturbances as noted in Table 3. Of these 212 patients, 110 (52%) conduction defects are noted and 20% involve the AV node. Associated AV nodal disease is more prevalent than can be noted by EKG, as shown by two studies. Narula¹³

TABLE 1
Diseases Associated with the SSS

Thyrotoxicosis	Hypertension
Drugs (e.g., digoxin, thioridazine)	Syphilis
Subarachnoid hemorrhage	Idiopathic myocardopathy
Myocarditis (viral and rheumatic)	Diabetes mellitus
Collagen disease (e.g., scleroderma)	Pericarditis
Friedrich's ataxia	Progressive muscular dystrophy
Amyloidosis	Hemochromatosis
Metastatic disease (e.g., reticulum cell sarcoma)	

TABLE 2
Arrhythmias and Their Frequency in SSS

Sinus bradycardia — 180 (30.1%)	Atrial tachycardia — 24 (4.0%)
Supraventricular tachycardia — 87 (14.4%)	Premature atrial contractions — 19 (3.1%)
Sinus Arrest — 67 (11.1%)	Ventricular Tachycardia — 17 (2.8%)
Junctional escape beats — 53 (8.8%)	Junctional tachycardia — 7 (1.2%)
Atrial fibrillation — 46 (7.6%)	Junctional premature beats — 4 (0.7%)
Premature ventricular contractions — 31 (5.1%)	Sinus tachycardia — 3 (0.5%)
Atrial flutter — 29 (4.8%)	Wandering atrial pacemaker — 3 (0.5%)
Sinus arrhythmia — 26 (4.3%)	

TABLE 3
Conduction Disturbances and their Frequency in SSS

First degree AV block — 40	Left bundle branch block — 12
Right bundle branch block — 26	Bilateral Bundle branch block — 3
Intraatrial block — 14	Second degree AV block — 2
Left anterior hemiblock — 13	

found that in 75 patients with sinus bradycardia, 67% manifested an AV conduction disturbance by His bundle electrogram. A similar study by Rosen et al¹¹ found eight of fifteen (53%) had an AV conduction disturbance. These conduction defects were thought to reflect underlying cardiac disease or other processes which seem to affect all cardiac conduction tissue, not just the SA node.

Diagnosis

The diagnosis of SSS should be considered when a patient complains of recurrent dizziness and/or syncope, and a sinus bradycardia is found by EKG. Holter monitoring for 12-14 hours may help, especially when symptomatology occurs with arrhythmias. If symptoms do not occur while monitoring, but an arrhythmia of the SA node does, the diagnosis should still be considered.

The overdrive suppression test has been used to test atrial automaticity in people suspected of having SSS. Rosen et al¹¹ found that by pacing the atrium at 150 beats per minute and then abruptly stopping, there was a post-pacing pause of 1073 ± 67 msec in normal subjects. In patients with SSS, the post-pacing pause was 3164 ± 334 msec. This abnormal response could be abolished in all patients with intravenous atropine, suggesting an important vagal influence in SSS. In Rosen's study, this prolonged asystole showed up in 4 out of 10 (40%) of patients with SSS; while Mandel et al¹⁴ found this in 29 of 31 patients (93%). Gupta et al¹² did similar studies, finding a prolonged post-pacing pause in 6 or 17 patients (35%) with SSS. However, he points out that the overdrive suppression test will not necessarily make the diagnosis of SSS, and it should not be used as the definitive test.

The effects of atropine have also been studied. Rosen et al¹¹ found the resting heart rate would not increase above 90 beats per minute after atropine (1 mgm IV) in 8 of

11 patients (73%) with SSS. Mandel et al¹⁴ again found similar results with a 25% rate increase in 27 or 31 (87%) with SSS, compared to an increase of 65% for normals. In a small number of these patients, a junctional rhythm appeared before the increase in sinus rate. Thus atropine may assist in the diagnosis of SSS if 1) resting heart rate does not increase as much as predicted for normals, and 2) if junctional escape beats occur before the increase in sinus rate.

Diagnosis should depend mainly on clinical signs and continuous monitoring. Support for this diagnosis can come from positive overdrive suppression tests (atrial pacing) or intravenous administration of atropine; but it should be remembered that a patient may still have SSS when these tests are negative.

Treatment

Drug therapy alone has been found to be of limited value. In a group of fifty-six patients with SSS, Rubenstein et al³ administered atropine chronically to combat bradyarrhythmias. The atropine appeared beneficial in only two cases out of the fifty-six and had no effect in another fourteen. In four cases, the atropine worsened the patient's condition by its side effects or the induction of tachyarrhythmias. Sympathomimetic amines were ineffective in eleven cases, and five were worsened by development of tachyarrhythmias. Ephedrine and isoproterenol were of definite benefit in only two patients. To summarize, of the 56 cases only six benefited from drug therapy, while the others noted little difference or even worsening.

Antiarrhythmic agents such as quinidine, procaineamide, and propranolol were of little help in patients with the bradycardia-tachycardia syndrome, only four of twenty-two receiving any benefit. Theoretically, these drugs may suppress tachyarrhythmias; however, they may also further depress an

already diseased SA node and any AV junctional escape focus.

Digitalis in combination with antiarrhythmic drugs benefited six of seventeen patients by decreasing the frequency of tachyarrhythmias or controlling ventricular response, while in four, digitalis alone was beneficial.

Good results have been obtained by transvenous placement of a right ventricular electrode. Conde et al⁴ reported a group of 31 patients receiving permanent ventricular pacemakers with the bradycardia-tachycardia syndrome. At time of insertion, thirty of the patients were given digitalis and/or an antiarrhythmic drug. A follow-up period of one month to 5 years showed 27 (87%) were free of symptoms, the other 13% having died. Chokshi et al⁸ reported similar results in 52 patients with a broader spectrum of SSS disease. Of these, 43 (83%) had relief of symptoms. The best results were noted in patients with only syncope and dizziness. The worst results were in the group presenting with heart failure, only 7 of 12 (51%) noting improvement. Generally, clinical status in terms of functional ability will change little using the New York Heart Association classification. Aroesty et al⁹ studied 28 patients with the bradycardia-tachycardia syndrome and found that while 26 (93%) had good control of the arrhythmia with a combination of pacemaker and drugs, functional class changed little. If a patient was symptomatic and in class 1 or 2, he became asymptomatic and stayed in his class. However, if the patient was in class 3 or 4, he might lose his symptoms from the arrhythmia, but he or she would not improve in functional cardiac status.

Prognosis

Aroesty et al⁹ have been the only ones to study factors underlying prognosis; and in general, they were related to underlying cardiac or renal disease. Four factors suggest a poor prognosis, i.e., death within one year: 1) severe limitation of physical activity either because of heart failure or angina pectoris (NYHA class 3 or 4); 2) valvular heart disease, particularly aortic stenosis, in association with coronary artery disease; 3) EKG evidence of left ventricular hypertrophy, old myocardial infarction, or ventricular tachycardia; 4) evidence of chronic primary renal

disease with a BUN greater than 40 milligrams percent. Evidence of cardiomegaly, angina pectoris, syncopal episodes, diabetes mellitus, and a history of hypertension were equally common in those surviving for greater or less than one year and are thus of little use in prognosis. Of 121 patients^{4, 8, 9, 15} documented causes of death in a five year period were:

Acute myocardial infarction	10
Resistant heart failure	2
Stroke	2
Pulmonary embolus	2
Chronic renal failure (including acute and chronic pyelonephritis)	2
Gram-negative septicemia	1
Ventricular fibrillation	1
Metastatic cancer	1

There were six cases where cause of death was not known. So 27 of 121 patients or 22% were dead within five years of diagnosis or pacemaker implantation. This gives a five year survival rate of 78%. No statistics showing age at time of death have been published.

Using all the above information, a protocol can be designed for the diagnosis of SSS. This is outlined in Figure 1. It should be suspected in any patient who presents with syncope, dizziness, or weakness and fatigue or any combination of these. A careful cardiac history should be elicited for symptoms of arrhythmia, MI (heart attack), heart failure, angina, or any other cardiac disease. Since much of the pathology causing the SSS is noncardiac in origin, a careful review of systems should not be neglected. Physical examination may reveal clues, for instance a bradycardia, atrial fibrillation, or an alternating bradycardia-tachycardia rhythm. One may also find signs of cardiac failure, neurologic disease, collagen disease or neoplasm. In general, the younger the patient, the more a noncardiac etiology should be searched for, unless there is a specific history such as cardiac surgery.

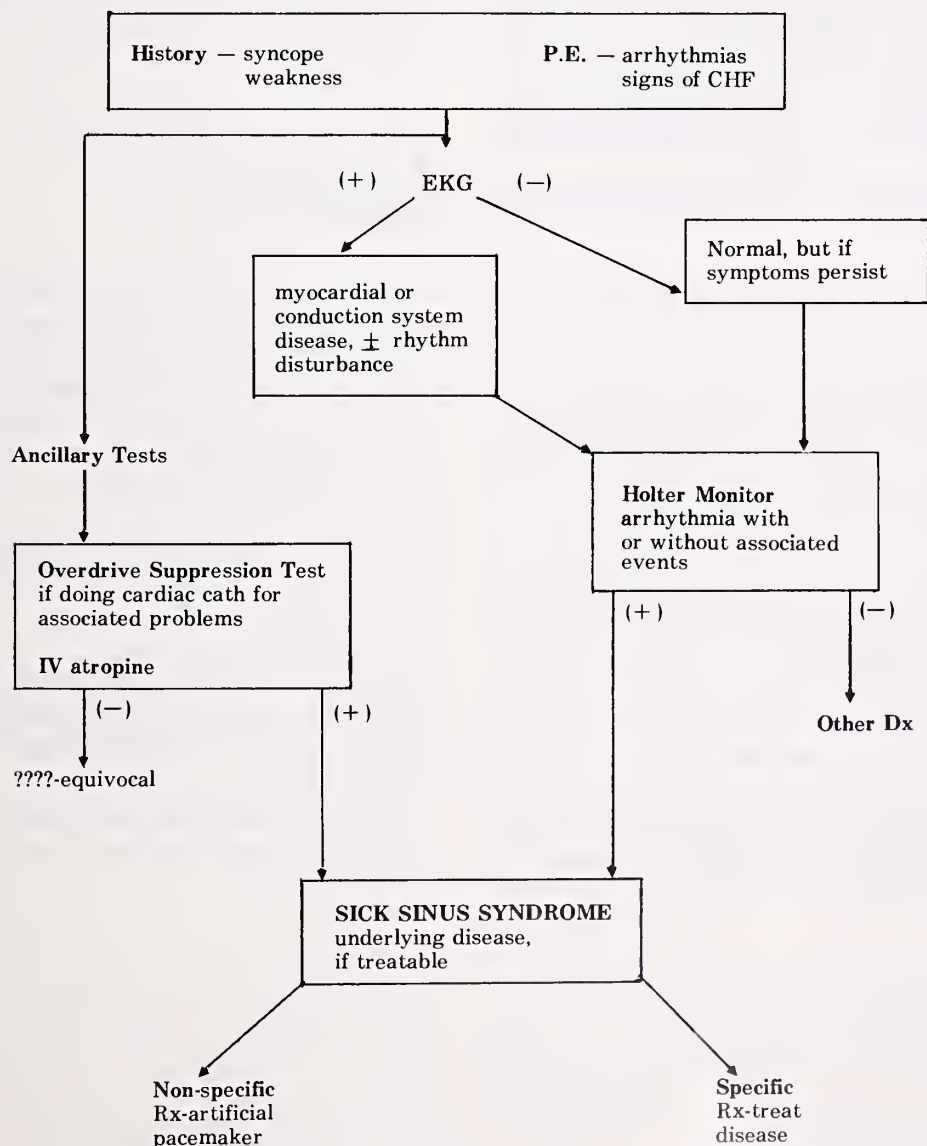
An EKG should be the first test done. It may reveal arrhythmias or disorders from the sinus node as well as evidence of conduction blocks, MI (new or old), or ventricular hypertrophy. A Holter monitor should be used for at least two twelve-hour periods, one during the day while recording his activities, and the other while sleeping at

night. This will allow more of a chance for any of the typical arrhythmias of SSS to be picked up. It is especially valuable if an arrhythmia is recorded during an episode of the presenting symptom(s).

At this point the diagnosis should have been made. However, if further supporting evidence is desired, an injection of atropine IV can be done to see how high the heart rate rises. An absence of a significant tachycardia (heart rate greater than 100 beats per minute) would support the diagnosis. If cardiac catheterization or coronary arteriography is to be done, the overdrive suppression test may be done, using the criteria described earlier. For most patients, treatment will be insertion of a pacemaker.

Summary

The sick sinus syndrome may present with vague symptoms such as syncope or fatigue. The most common etiology is coronary artery disease, while in a significant number no cause will be found. Arrhythmias will usually be found in combination with other abnormalities of the EKG, usually a conduction disturbance. Diagnosis is based on a careful history and physical examination with continuous monitoring for arrhythmias for a 12-24 hour period as the main aid to diagnosis. The use of intravenous atropine and the overdrive suppression test may aid in the diagnosis, but should not be looked upon as definitive. Artificial pacing forms the basis of therapy.



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Down Memory Lane

1: No patient develops a diabetic coma suddenly.

2. At present there are too many more or less independent agencies at work with a multiplicity of bureaus and clinics and each one has, or seems to have, a health program to put over many times impractical.

3. We have information that assures us that the city of Hastings will be well able to care for all who wish to attend the annual meeting of the Nebraska State Medical Association, May 15-17.

4. I collected about \$600 the first year and not much more the second.

5. If a lawyer wins a \$10,000 lawsuit, even though it requires less time and effort on his part, he gets more for it than for winning a

\$100 one. If the physician is able to save the life and time of a man who draws \$10,000 a year, he is on the same basis entitled to a greater return than for the same services to a man who earns \$5 a day. Therefore, in one of its aspects, a physician's fee should be a percentage of a salvage value.

6. The city of Lincoln has passed an ordinance making it a felony to apply for and receive medical treatment at a free clinic if able to pay.

7. The laboratory is the assistant to the physician, a right arm if you please, not his master. It can never replace trained hands, eyes and ears.

Nebraska State Medical Journal
March, 1928

President's Page

WE OWE THEM MORE

It is the medical student of whom I speak. I have followed medical students in their process of learning, for a number of years. They acquire their scientific knowledge, then go out into the world to save life and limb and ameliorate suffering. However, I feel, we as their predecessors and mentors, owe them at least four things during their career as a student.

The first obligation is to the incoming medical student. We owe this incoming medical student a better method of determining his qualifications for medical school. Sure, you say medical schools take only A students with good character reference. Is this restrictive enough? I don't think so. Finding a brilliant student and making a doctor out of him because he is able to assimilate the scientific knowledge is not enough. Being a doctor requires a great deal of personal input. Therefore, there should be some way to measure the prospective student's psychological motivation to become a doctor and eliminate those that do not have the temperament, patience, integrity, moral character, and willingness to sacrifice for the sake of the sick. This would eliminate those going to medical school only because they had the grades to get in, or because they had to further their education and it might as well be in medicine.

Number two, we should offer an easier way out of medical school. There are a miniscule number that once in medical school are carried from year to year, not quite flunking out or doing anything bad enough to warrant expelling from school and yet would make room for some excellent student were he to step down and say medicine is not for him. Also, I would like to see professors have the courage to tell him he might do better in another field. Course, this would require the medical schools to take the heat from the parents when the favorite son or daughter left medical school under these conditions. What I am trying to say, there should be an easier way to get out of medical school, there should be an easier way to get



out of the whirlwind of medical education if one does not wish to go all the way.

Third, we need to teach students more of what the patients really look for in a doctor, and that is kindness, consideration, understanding, and feeling, with which the old time doctors practiced with abundance although limited in scientific knowledge. I believe there could be a pleasant blend of the two, scientific knowledge and what a patient looks for, we owe it to the student to teach both modalities.

And lastly, somewhere along the educational route should be an avenue of exposure to medical costs. I feel strongly about the need of awareness of medical costs. All scientific books on medicine are written sans dollar signs. Sure, we have the finest medical care in the world, it is expensive and worth every penny, but I feel students should have courses emphasizing this fine medical care at efficient costs without sacrificing the quality of medical care.

To sum up, I feel we owe medical students better entrance exams, better means to get out of the program, more emphasis on empathy, and more concern for the cost of medical care.

Arnold Lempka, M.D.



The Auxiliary

THE TIME IS NOW

Many spouses are very active in legislation right now. Enthusiasm and work has reached a new high.

Wives in one auxiliary are not only attending but are also monitoring meetings of groups that have anything to do with health planning. Time to cover all of these meetings is difficult for a physician to find. This is a very valuable service that you can provide for your medical society. There is no better way to become informed.

As well as attending meetings, the Greater Omaha Medical Society Auxiliary has organized the individuals that will write letters and wish to be involved in legislation. Each of ten callers have eight or ten to be called. This is an active alert system that can be used for both state and national legislation.

Here is another new development. The Greater Omaha Medical Society has now a member of the Auxiliary on every committee

that has a common interest or activity. The Auxiliary no longer has to wonder what the society is planning or thinking. The President-elect of the Auxiliary sits in on the Medical Society planning committee. Conventions and future activity can be coordinated. This will provide a continuity from year to year.

To my knowledge this is all new in this state. It is particularly the younger group of wives that have sparked a whole new interest to provide an answer to that old question, "What do they do? Do they accomplish anything?"

Is every physician in your society registered to vote? You may be surprised. Is every spouse registered?

The future of medical care, your future, and your children's future are all being measured. Isn't it about time you helped?

Dorothy Lovgren
Legislation Chairman
Nebraska Medical Society Auxiliary

Our Medical Schools

Courses at U of N.

1. Seven nationally known specialists will speak at a course on obstetrics and gynecology sponsored by the University of Nebraska Medical Center and Creighton University School of Medicine Thursday and Friday, March 9 and 10. The course will be presented at the Omaha Hilton.

Guest speakers include Drs. Norman Gant, University of Texas Health Science Center at Dallas; Clifford Goplerud, University of Iowa; William J. Ledger, University of Southern California at Los Angeles; John McLean Morris, Yale University School of Medicine; Michael Newton, McGaw Medical Center of Northwestern University; and

Daniel Roberts, University of Kansas School of Medicine; and Karen Clark, independent consultant in the area of human relations from the Minnesota State Department of Education.

Course coordinators are Drs. Joseph Scott and Robert Luby, chairmen of their respective departments at the University of Nebraska and Creighton University, and Shirley Young, R.N.

The program is acceptable for 12 prescribed hours by the American Academy of Family Physicians.

Registration is \$75 for physicians and \$55 for other members of the health team.

The obstetric course will be preceded by a course on the assessment of fetal well-being Wednesday, March 8, at the University of Nebraska Medical Center.

Coordinators of this course are Drs. John W. Goldkrand and Glenn Haswell, associate professor of obstetrics and gynecology at the University of Nebraska Medical Center.

Registration fee is \$35 for physicians and \$22.50 for non-physicians.

2. A symposium on myocardial preservation has been scheduled as part of the Midwest Student Medical Research Forum being held at the University of Nebraska Medical Center Friday, April 7.

Taking part in the symposium will be Drs. G. Frank O. Tyers, University of Texas Medical Branch at Galveston; Jesse E. Edwards, United Hospitals, Miller Division, St. Paul, Minnesota; Robert Hall, Texas Heart Institute, Houston; and Ezra Amsterdam, University of California at Davis.

Students from 50 medical schools from western United States will participate in the forum April 6 through 8 at the Medical Center.

Creighton allergy center.

The Creighton University Allergic Disease Center has been presented with a \$12,500 computerized spirometer by Boehringer Ingelheim, Ltd., a manufacturer of pharmaceuticals.

Robert Townley, M.D., Professor of Medicine and Director of the Center, said the new instrument is the most sophisticated spirometry system available and is used to measure the air capacity of the lungs.

The Allergic Disease Center is located in the Dr. C. C. and Mabel L. Criss Health Sciences Center on the Creighton campus. It is one of only 15 centers, nationwide, so designated by the National Institute for Health.

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Between Cases

Section On Advice.

Never play cards with a man called Doc.
Never eat in a place called Mom's.
Algren.

Division Of Pathology.

The left ventricle is tilted.
Leslie Miner: Psychic.

The Metric System.

One dekamicroday = 0.864 second, = 10
microdays.

Words I Can Do Without.

Signed sealed and delivered, I would be
remiss, between you and me and the
lamp-post, an idea whose time has come.

Beginnings Of Answers To Difficult Questions.

I'm afraid that any answer . . .
Anything is possible . . .
There is no simple basis . . .

In What?

The ligament was torn in its substance.

Quote Unquote.

The physician must have at his command
a certain ready wit, as dourness is
repulsive both to the healthy and to the
sick.

Hippocrates.

Why?

Why do we say rate and rhythm regular?
The rhythm is even or uneven. The rate
is just a number.

Section On Diagnosing.

The patient was operated on and the
diagnosis proven.
Did it help?

This Was Part Of The History.

This so often goes with that.

Heard On TV.

I question if there will be if there will be
excess capacity in the market.

—F.C.

In Memoriam

*By medicine life may be prolong'd
yet death*

Will seize the doctor too.

—Shakespeare

DR. STEPHEN L. MAGIERA

Doctor Stephen L. Magiera died on October 21, 1977, at the age of fifty-seven. Doctor Magiera was a native of East St. Louis, Illinois.

He graduated from Creighton University School of Medicine in 1944 and began his internal medicine practice in Omaha in 1948.

He is survived by his wife, Ann; sons, Stephen Jr. of Washington, D.C., and Paul of Omaha; daughters, Kathy of San Diego, Calif., and Marilee, Karen and Mimi of Omaha.

DR. WILLSON B. MOODY

Doctor Willson B. Moody died on November 25, 1977, at the age of eighty-five. He was born in Kansas City, Missouri, on June 14, 1892.

He graduated from Rush Medical College in 1919. He was a former Chairman of the

Department of Medicine at the University of Nebraska College of Medicine.

Doctor Moody was recognized by the Nebraska Medical Association as a fifty-year practitioner in 1969.

He is survived by his sons, Willson B. Moody, Jr., Thunder Bay, Ontario, Canada, and Dr. Edson D. Moody, Hagerstown, Md.

DR. CHARLES M. MURPHY

Doctor Charles M. Murphy died on October 22, 1977, at the age of seventy-nine. He was born in Utica, New York, on January 20, 1898.

He was graduated from Creighton University School of Medicine in 1925. He maintained a general practice in Omaha for the major portion of his career and also spent 10 years with the Veterans Administration.

Doctor Murphy was recognized by the Nebraska Medical Association as a fifty-year practitioner in 1975.

He is survived by his wife, Marguerite; sons, James, a Douglas County District Court Judge, Dr. William, Charles and Daniel; daughter, Mrs. Joseph Malloy, all of Omaha; and 24 grandchildren.

Coming Meetings

CRIPPLED CHILDREN'S CLINICS —

March 11 — Kearney, Elks Lodge

March 18 — Sidney, Elks Lodge

April 1 — Broken Bow, Elks Lodge

April 15 — Hartington, Trinity Lutheran Church

NEBRASKA MEDICAL ASSOCIATION ANNUAL SESSION — April 30 - May 3, 1978, Lincoln Hilton Hotel, Lincoln, Nebraska.

THE FIRST INTERNATIONAL SYMPOSIUM OF THE INTERNATIONAL COLLEGE OF PEDIATRICS — June 18-22, 1978, Finlandia Hall, Helsinki, Finland. Plenary Sessions, Symposia, Round-table discussions, Free papers. George D.

Maragos, M.D., M.Sc., Associate Professor of Pediatrics, Creighton University Medical School, Omaha, Nebraska, 68108, USA.

AMERICAN MEDICAL ASSOCIATION — Annual Convention, June 17-22, 1978, St. Louis, Missouri.

NEBRASKA MEDICAL ASSOCIATION FALL SESSION — September 21-23, 1978, Lincoln Hilton Hotel, Lincoln, Nebraska.

AMERICAN MEDICAL ASSOCIATION — Interim Session, House of Delegates, December 2-6, 1978, Palmer House, Chicago, Illinois.

AMERICAN MEDICAL ASSOCIATION — Winter Scientific Program, December 7-10, 1978, Las Vegas, Nevada.

Books



Managing nonprofit organizations; edited by Diane Borst and Patrick Montana; 328 pages; published 1977 by Amacom, a division of American Management Associations, N.Y.; hardcover \$16.95.

Can nonprofit organizations be managed, and does this not concern us? The book consists of five chapters and 30 sections written by 30 authors; and these are some of the section titles: Systematic processes applied to health care planning; Systems planning, tomorrow's hospitals today; Tailoring MBO (management by objectives) to hospitals; Matrix organizational design as a vehicle for effective delivery of public health care and social services.

There is more, in detail. It is suggested, in a reference (p. 119) that 9 out of 10 Americans are medically indigent. Elsewhere (p. 182) we read that (hospital) administrators must not rely on money to solve all their problems.

Should a hospital be a doctor's facility? Ought it to center on major health needs, we are asked, or be "abreast of every medical advance," no matter how seldom some devices are going to be used? We are familiar with much of this, it is our business. But it can't hurt to read. This is good reading.

—F.C.

Physicians' Classified

Advertisements in this column are run at a rate of twenty cents per word with a minimum of \$10.00 per insertion. Copy must be received by the fifth of the month preceding date of publication and should not exceed 50 words. Each advertisement will be taken out following its first appearance unless otherwise instructed. Where numbers follow advertisements, replies should be addressed in care of The Nebraska Medical Journal, 1902 First National Bank Building, Lincoln, Nebraska 68508.

PSYCHIATRIC RESIDENCY: Vacancies for (PG2 through PG4 only) positions for July 1, 1978, for those who have a regular Iowa license or can obtain one by reciprocity or via FLEX. Prepare for career in private practice, community clinics or hospital-based psychiatry. Emphasis on close supervision of intensive individual and group psychotherapy, OPD, Children's Unit, Adolescent Unit. Neurology affiliation with University of Iowa. The stipends are: 1st year, \$22,360; 2nd year, \$23,478; 3rd year, \$24,674. Intensity and diversity of training program appreciated best by personal visit. T. B. McManus, M.D., Superintendent, Mental Health Institute, Cherokee, Iowa 51012. Equal Opportunity Employer. Call Collect 712-225-2594.

SITUATION WANTED — Board qualified general internist, age 55, special interest in rheumatology and alcoholism and related consequences seeks position in group or associated practice, licensed in Nebraska. Contact Box #64, NEBRASKA MEDICAL JOURNAL, 1902 First National Bank Building, Lincoln, NE 68508.

EMERGENCY ROOM PHYSICIAN — Immediate opening for qualified physician. New hospital; new modern E.R. Dept. Good working conditions with all supportive services. Four - twelve-hour days per week. No weekends. Contact: Administrator, Lutheran Memorial Hospital, 2116 West Fairley, Grand Island, NE 68801 (308) 382-3890.

WashingtonNotes

Health planning guidelines.

The federal government has released a second version of the controversial health planning guidelines, saying the revised rules contain "enough flexibility to be fair, and are tough enough to be effective."

HEW Secretary Joseph Califano emphasized that the guidelines are to serve as national standards for local Health Systems Agencies and state health planning bodies, which must make the final decisions.

The Secretary said HEW's ability to enforce the guidelines is limited to two areas. One, if a local hospital proceeded with capital expenditures in violation of a state adopted plan, HEW could withhold funds that are provided for reimbursement of depreciation costs. Two, HEW does have the power to "decertify" local HSAs that completely disregard the guidelines. However, Califano stressed that planning authority rests in local hands.

The revised guidelines propose these major standards:

- **A maximum of four hospital beds per 1,000 people.
- **An average annual occupancy rate of at least 80 percent for hospitals in a Health Service Area.
- **At least a 75 percent average occupancy rate and at least 1,500 births annually for hospitals that provide care for complicated obstetrical problems.
- **No more than four neonatal intensive and intermediate care beds per 1,000 live births.
- **A minimum of 20 beds for pediatric units in urban areas.
- **Average annual occupancy rate ranging from 65 percent to 75 percent for pediatric units, based on their size.
- **At least 200 open heart procedures annually in any institution in which open heart surgery is performed for adults, and at least 100 heart operations annually in any institution in which pediatric open heart surgery is performed.

**At least 300 cardiac catheterizations annually in any adult catheterization unit, and at least 150 cardiac catheterization units annually in any pediatric catheterization unit.

**A service area with a population of at least 150,000 people, or treatment of at least 300 cancer cases annually, for megavoltage radiation therapy units.

**At least 2,500 procedures per year for each computed tomography scanner.

**Plans consistent with already established HEW standards and procedures for suppliers of end-stage renal disease services.

Fraud & abuse.

More than 2,400 doctors and druggists providing subsidized health services to needy persons have been identified as having patterns of practice indicating a likelihood of fraud and abuse, HEW Secretary Califano has said.

He announced new details of Project Integrity, a program of HEW searching for corruption in subsidized medical care.

HEW has issued regulations, required under 1977 anti-fraud legislation, that set requirements for states creating fraud and abuse control units to monitor the federal-state Medicaid program.

The units should operate separately from the agency administering a state Medicaid plan, have the capacity to prosecute fraud or refer allegations of fraud to prosecutors, and investigate complaints from patients in nursing homes and mental institutions.

If states create such units, HEW will reimburse them for 90 percent of their operational costs, a government spokesman said.

Califano said Project Integrity has screened the billing claims of all 275,000 Medicaid physicians and pharmacists "and identified over 2,400 with patterns of practice indicating a likelihood of fraud and abuse."

More than 450 of the 2,400 doctors and druggists are being investigated for potential Medicaid abuses.

Another 400 are undergoing "detailed field checks for potential criminal fraud," Califano said.

Physician shortage.

The number of Americans living in areas officially designated as having a physician shortage could increase by 56 percent to a total of 25 million under new criteria proposed by HEW.

Communities designated as having a physician shortage are eligible to apply for physicians services provided through HEW's National Health Service Corps or related federal programs. Of the estimated 25 million people, 15 million reside in inner cities according to the definition of what constitutes a shortage area. The remaining 10 million are in rural areas.

Health care cost.

The cost of health care has risen for the population as a whole from 6.2 percent of the Gross National Product in 1967 to 8.6 percent of the GNP in 1976. During these same years the cost for a semiprivate hospital room rose 169 percent and operating room costs rose 175 percent.

HEW reports that 29 percent of the Nation's health care expenditures in 1976 were for treating those over 65. Per capita annual expense in this age group was \$1,521.

The share of public funding for health care in the elderly has risen from 30 percent in 1966 to 68 percent in 1976, and the number of beds in nursing homes tripled between 1963 and 1973.

Between 1950 and 1974 the number of physicians in the United States rose 70 percent from 232,697 to 394, 448. The ratio of physicians to population increased 22 percent in this period from 14.9/1,000 to 18.2/1,000.

Physician visits per person per year was 5.0 in 1973 and 4.9 in 1976. The average length of a hospital stay was 8.1 days in 1973 and 7.9 days in 1976. The percentage of persons with one or more hospitalizations in one year was 10.7 percent in 1973 and 1976.

Hospital discharges per 100 persons per year totaled 13.9 in 1973 and 14.1 in 1976.

Surgery & inappropriate utilization.

Under a HEW contract, the American Association of Professional Standards Review Organizations has identified 11 surgical procedures which it says "have a significant potential for inappropriate utilization."

The Association's national council has adopted a set of screening criteria for these procedures which will be sent to local PSROs. The surgical criteria "must not be viewed by local PSROs as mandating national standards," says the Chairman of the Association's Surgical Criteria Committee, John Bussman, M.D., of Portland, Ore.

The 11 surgical procedures are: abdominal hysterectomy, vaginal hysterectomy, coronary arteriography, cataract removal, dilatation and curettage, tonsillectomy and adenoidectomy, cholecystectomy, hiatal hernia repair, lumbar disc excision for rupture or protrusion, meniscectomy, and appendectomy.

With respect to vaginal and abdominal hysterectomy, a subject of national attention, the national council said:

"Sterilization by abdominal (or vaginal) hysterectomy is acceptable only in the presence of concomittant uterine disease."

Blood donors.

All whole blood drawn after May 15, 1978, for transfusion must be labeled "paid" or "volunteer" donor.

The final regulation of the FDA specifies that persons who do not receive monetary payment for blood are classified as volunteers. The "volunteer" designation includes those who receive benefits other than money, such as membership in a blood assurance program or leave from work.

The labeling requirement also covers red blood cells, antihemophilic factor, platelet concentrate, and single plasma.

The blood labeling rule caps a lengthy nationwide debate on national blood policy. In issuing the regulation, FDA Commissioner

Donald Kennedy, PhD, said the labeling rule is "consistent with the goals of the government's national blood policy to move the country to an all volunteer system."

The incidence of post-transfusion hepatitis has been reported to be three to ten times higher with blood from paid donors versus blood from volunteers.

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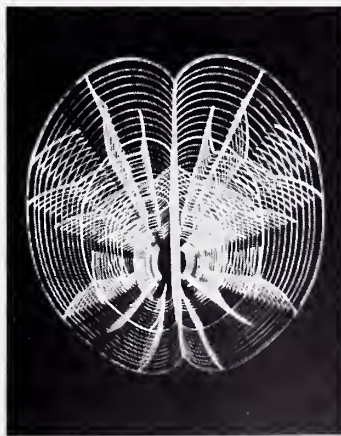
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; ataxia; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindications: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs



such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect.

Adults: Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.;

adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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Dosage and Administration: Wash affected areas prior to application. Apply once or more daily or as directed by physician.

Contraindications: Should not be used by patients having known sensitivity to either benzoyl peroxide or polyoxyethylene lauryl ether.

Precautions: For External Use Only. Not for ophthalmic use. Keep away from eyes and mucosae. Very fair individuals should begin with a single application at bedtime allowing overnight medication. May bleach colored fabrics. Keep this and all other medications out of the reach of children.

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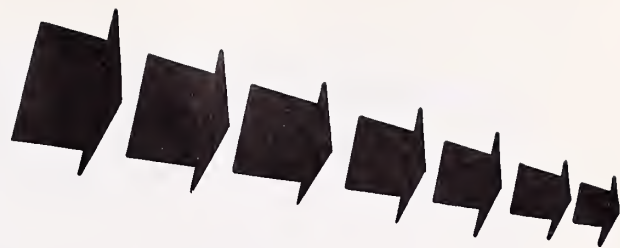
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1978 ANNUAL SESSION

OF THE

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REFERENCE COMMITTEES
ANNUAL RECOGNITION AND RELIGION
BANQUET
Recognition of Fifty-Year Practitioners
Speaker: The Reverend Father
Clifford Stevens

MONDAY — MAY 1

HOUSE OF DELEGATES
NOMINATING COMMITTEE
SPORTSMAN'S DAY

TUESDAY — MAY 2

SCIENTIFIC BREAKFAST MEETING
Speaker: LCDR Michael F. Boyer,
MC, USN
SYMPOSIUM ON BIOFEEDBACK
ATHLETIC — MEDICINE LUNCHEON
Speaker: Mr. George Plimpton
SYMPOSIUM ON CIRCADIAN RHYTHMS
FUN NIGHT
Entertainment: Mr. Mark Russell

WEDNESDAY — MAY 3

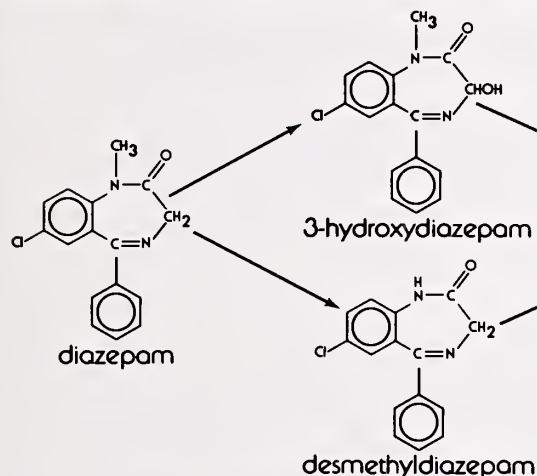
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SYMPOSIUM ON "WHAT'S NEW IN
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— Installation of 1978-1979
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— Speaker: Mr. Irving R. Levine



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Valium® (diazepam) ^(IV)

2-mg, 5-mg, 10-mg scored tablets
a prudent choice in psychic
tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due

to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The

physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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An NMA 110th Annual Session highlight

SYMPOSIUM ON BIOFEEDBACK



featuring

John V. Basmajian, M.D.
Director, Rehabilitation Centre
Chedoke Hospitals
Hamilton, Ontario, Canada

Moderator

Jerry A. Reed, M.D., Lincoln
Internal Medicine

Tuesday, May 2
9:00-12:00 Noon

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Early Detection of Breast Cancer — G. R. Stewart et al (54 Kitchener Parade, Bankstown, NSW, Australia, *Med J Aust* 2:419-423 (Sept 24) 1977.

One thousand referred patients with breast symptoms, a history of breast disease, or a family history of breast carcinoma were examined at a suburban breast clinic. This is a preliminary survey of the data and results so far obtained from the initial examination of these patients, which consisted of history-taking by means of questionnaire, physical examination of the breasts, thermography, and xeromammography. A report correlating the findings was forwarded to the referring doctor in each case and any necessary action was indicated in the report. Seventy-eight patients were thought to require biopsy of a suspicious lump or mammographic lesion (7.8% of the total number); 76 patients actually had biopsies, and 18 were found to have carcinoma of the breast (23.8% of the total number of patients who had biopsies). The overall incidence of carcinoma in the 1,000 women attending the clinic was 1.8% at the initial visit. While general population screening for breast carcinoma may be difficult to justify, from both the detection rate and an economic point of view, it would appear from this experience to date that screening of selected high-risk referred patients is justified and, in fact, desirable.

Mortality Among Women Participating in the Oxford/Family Planning Association Contraceptive Study — M. P. Vessey et al (Univ of Oxford, Oxford, England) *Lancet* 2:731-733 (Oct 8) 1977.

Forty-three deaths are known to have occurred among the 17,032 participants in the Oxford/Family Planning Association contraceptive study up to the end of April 1977. Nine deaths from cardiovascular causes were observed among the women in the oral contraceptive entry group (46,681 woman-years of observation) while no such deaths were observed among the women who entered the study while using a diaphragm or an intrauterine device (39,146 woman-years of observation).

Tablets **Percodan®**

DESCRIPTION Each yellow, scored tablet contains 450 mg. oxycodone HCl (WARNING: May be habit forming), 0.38 mg. oxycodone terephthalate (WARNING: May be habit forming), 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.

INDICATIONS For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS Hypersensitivity to oxycodone, aspirin, phenacetin or caffeine.

WARNINGS **Drug Dependence** Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of PERCODAN®, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, PERCODAN® is subject to the Federal Controlled Substances Act.

Usage in ambulatory patients Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using PERCODAN® should be cautioned accordingly.

Interaction with other central nervous system depressants Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with PERCODAN® may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Usage in pregnancy Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, PERCODAN® should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Usage in children PERCODAN® should not be administered to children.

Salicylates should be used with caution in the presence of peptic ulcer or coagulation abnormalities.

PRECAUTIONS **Head injury and increased intracranial pressure** The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions The administration of PERCODAN® or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special risk patients PERCODAN® should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

Phenacetin has been reported to damage the kidneys when taken in excessive amounts for a long time.

ADVERSE REACTIONS The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include euphoria, dysphoria, constipation and pruritus.

DOSAGE AND ADMINISTRATION Dosage should be adjusted according to the severity of the pain and the response of the patient. The usual adult dose is one tablet every 6 hours as needed for pain.

DRUG INTERACTIONS The CNS depressant effects of PERCODAN® may be additive with that of other CNS depressants. See WARNINGS.

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1. Determine need

What is causing pain? How is it perceived by you and your patient?

2. Prescribe a rapid-acting agent

Select a readily-absorbed oral agent that usually acts within 15 to 30 minutes.

3. Minimize potential risk

Prescribe in limited quantities for selected patients.

Schedule II classification means no refills, no telephone Rx. Patients with persistent pain must return for your evaluation of analgesic needs.

4. Provide adequate analgesia with minimum doses

Consider PERCODAN® because patients rarely ask for increased dosage. PERCODAN® relief can last up to six hours—until time for next tablet.

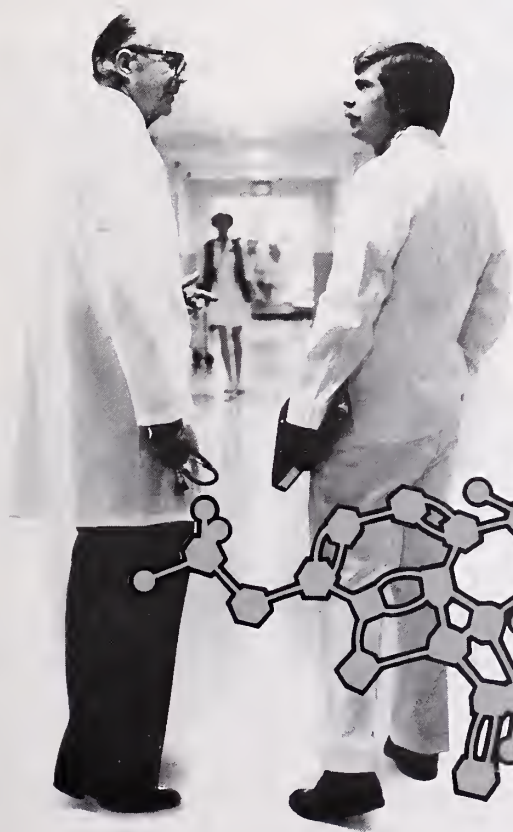
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NMA 110th Annual Session — Tuesday, May 2

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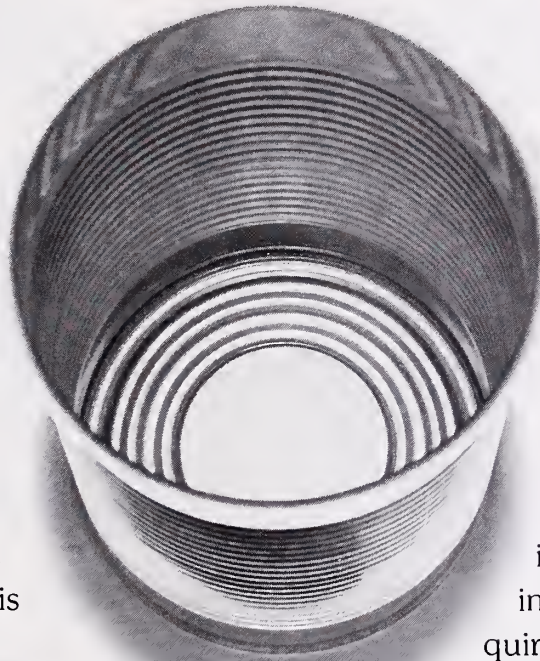
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NOW a two-piece 14oz. can for Soyalac



A two-piece can means no soldered seam. No solder means no possibility of lead contamination from the container. Soyalac is the first infant formula with this packaging innovation.

There are improvements, too, in the formulation. Soyalac now has 25% more iron than known competitive hypoallergenic milk-free formulae. In fact, the entire formula has been slightly modi-

fied to reflect the current U.S. RDA levels set by the Food and Drug Administration.

Soyalac — formula for infants on regular feeding and for those who require milk-free diets; concentrate and single strength, ready-

to-use. Made from the whole soybean. I-Soyalac concentrate, made from soy isolate, with no soy carbohydrates and **no corn products**.



For detailed information and samples call or write:

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(614) 397-7077

Loma Linda®

Radical Mastectomy for Operable Breast Cancer — H. Freund et al (Hadassah Univ Hosp, Jerusalem, Israel) *J Surg Oncol* 9:487-492 (Sept) 1977.

The experience with radical mastectomy in the treatment of 152 cases of operable breast cancer has been analyzed. An overall five-year survival of 75% and ten-year survival of 62% are reported and compared with results from other methods of treatment. Based on the excellent survival rates achieved and the low incidence of local recurrence (9.8%), the present study suggests that radical mastectomy is still the most suitable surgical procedure in the treatment of operable breast cancer.

Medical Treatment of Angina Pectoris — R. A. O'Rourke (Div of Cardiology, Univ of Texas Health Science Center, San Antonio, TX 78284) and M. H. Crawford, *Cardiovasc Med* 2:839-848 (Sept) 1977.

The determinants of myocardial oxygen consumption include the magnitude of systolic myocardial wall tension, the fraction of time during which the peak tension is exerted, and the contractile force of the heart. Factors regulating coronary blood flow include aortic diastolic pressure, left ventricular (intramyocardial) diastolic pressure, right atrial pressure, and resistance to blood flow at the arteriolar level. Myocardial ischemia occurs when myocardial oxygen demand exceeds the capacity of diseased vessels to deliver oxygen. Medical therapy of angina pectoris is based on the use of nitrates and beta adrenergic blocking agents, which act primarily by decreasing myocardial oxygen demand. Nitroglycerin decreases left ventricular wall tension, by reducing ventricular volume (venous dilatation) and systolic pressure (arteriolar dilatation), and decreases the left ventricular ejection time. Propranolol reduces myocardial oxygen demand by decreasing systolic blood pressure, heart rate, and myocardial contractility at rest, and attenuating their increase during exercise. Selection of the appropriate preparations and dosages of these two medications is basic to preventing episodes of angina pectoris.

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

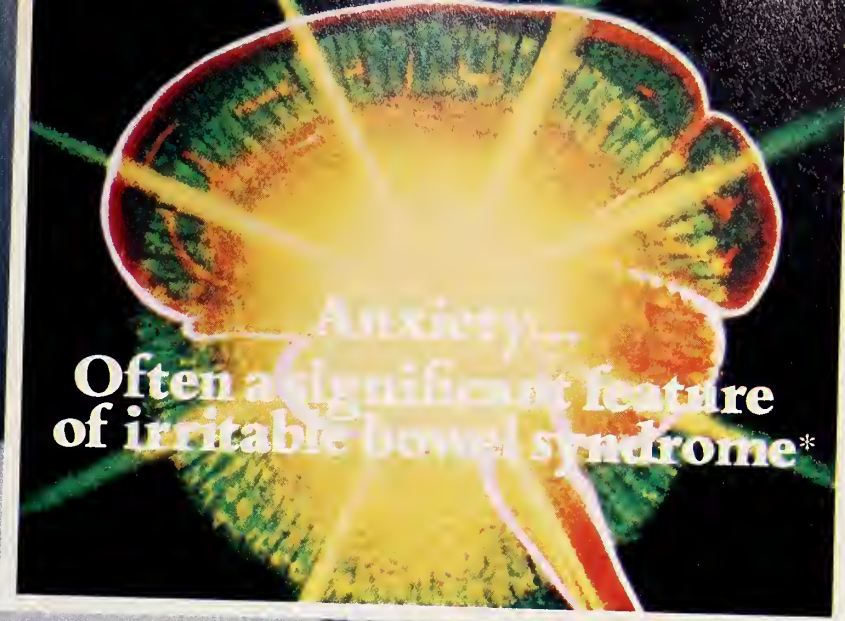
Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.





Anxiety...
Often a significant feature
of irritable bowel syndrome*

The action of
Librium®
(chlordiazepoxide HCl)

A significant advantage
of adjunctive

Librax®

Each capsule contains
5 mg chlordiazepoxide HCl and
2.5 mg clidinium Br.

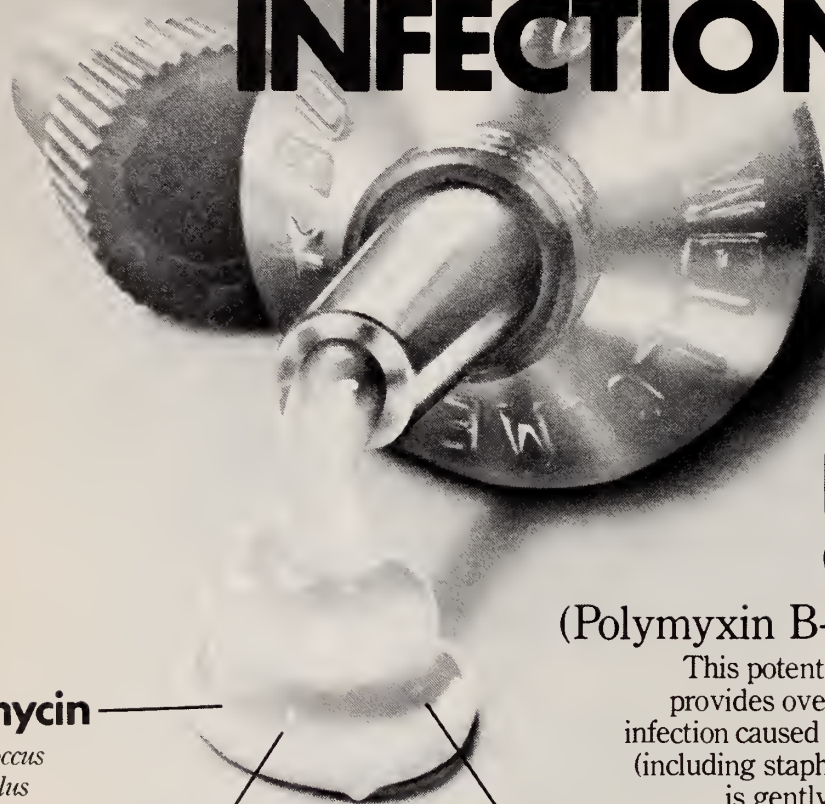
Antianxiety
Antisecretory
Antispasmodic

Librax is unique among G.I. medications in providing the specific antianxiety action of Librium® (chlordiazepoxide HCl) as well as the potent antisecretory and antispasmodic actions of Quarzan® (clidinium Br) for adjunctive therapy of irritable bowel syndrome* and duodenal ulcer.*

has been evaluated as possibly effective for this indication.
See brief summary of prescribing information on preceding page.

ROCHE

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Neosporin Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogen (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

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Staphylococcus
Haemophilus
Klebsiella
Aerobacter
Escherichia
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Corynebacterium
Streptococcus
Pneumococcus

Bacitracin

Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B

Pseudomonas
Haemophilus
Klebsiella
Aerobacter
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In vitro overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).



Burroughs Wellcome Co.
Research Triangle Park
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Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is

affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparation prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE **DYAZIDE®**

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. Brief summary follows:

Warning

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Indications: When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops. If dietary intake of potassium is markedly impaired, supplementary potassium is needed, potassium supplements should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated prolonged QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids).

Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

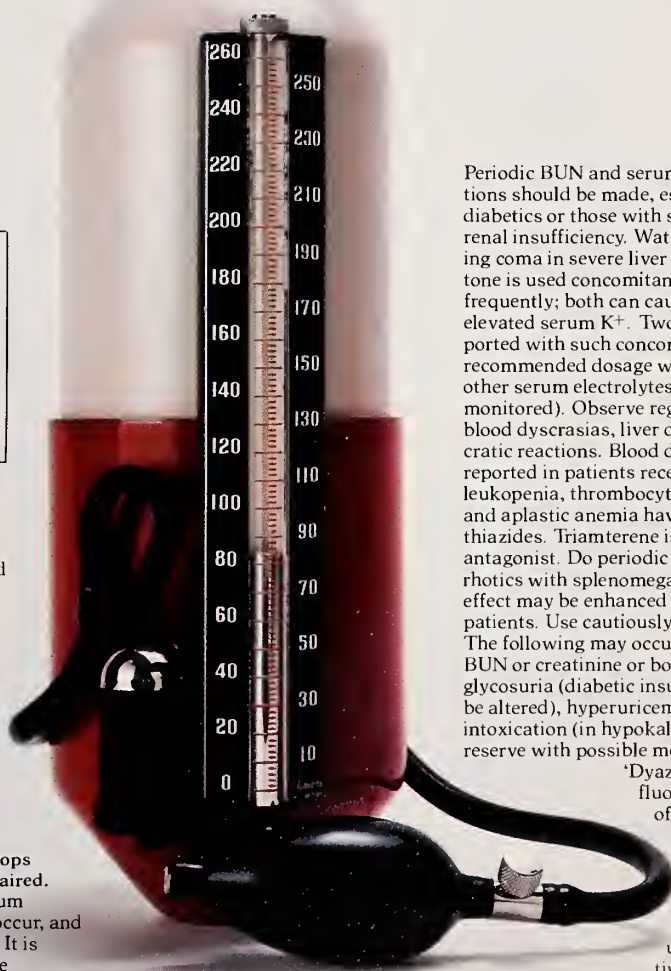
'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions:

Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions;

nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).



**FOR LONG-TERM CONTROL
OF HYPERTENSION*
SERUM K⁺ AND BUN SHOULD
BE CHECKED PERIODICALLY.
(SEE WARNINGS SECTION.)**

SK&F CO., Carolina, P.R. 00630

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a SmithKline company

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**Signs Certificate of Ratification
at His Home Without
Women Witnesses.**

MILITANTS VEXED AT PRIVACY.

**Wanted Movies of Ceremony,
But Both Factions Are**

WASHINGTON, Aug. 26, 1920—
The struggle for Women's



TRUMAN CLOSES UNITED NATIONS CONFERENCE WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

**President Hails 'Great
Instrument of Peace,'
Insists It Be Used**

HISTORIC LANDMARK

**Meeting Gives Standing
Ovation as Executive
Pictures Peace Gain**

Social Security Bill Is Signed, Gives Pensions to Aged, Jobs

**Roosevelt Approves Message Intended to Benefit 30,000,000
Persons When States Adopt Cooperating Laws—He
the Measure 'Cornerstone' of His Economic Program**

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

**Amendment to Constitution
is Sent to House, Where
Passage is Expected**

**WASHINGTON, March 10,
1971—The Senate approved
today, 94 to 0, and sent to**

WASHINGTON, Aug. 1
The Social Security Bill, providing a broad program of unemployment insurance and old age pensions and counted upon to benefit 20,000,000 persons, became law today when it was signed by President Roosevelt in the presence of those chiefly responsible for getting it through Congress.

Mr. Roosevelt called the bill "the cornerstone in the program which is being built to help men's complete economic recovery."

the Draft Ends Now

**WASHINGTON, Jan. 27,
1973—"With the signing of
the peace agreement in
Paris today, and after receiving a report from the**

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA

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6910 Pacific Street, Omaha 68106

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Karen Mundy, Associate Director
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National Multiple Sclerosis Society —

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University of Nebraska Medical Center

Neal A. Vanselow, M.D., Chancellor
42nd and Dewey Avenue, Omaha 68105

Survival After Spinal Cord Trauma — L. Mesard et al (Biometrics Div, Veterans Administration, Washington, DC 20420) Arch Neurol 35:78-83 (Feb) 1978.

The records accruing from the care of spinal cord injury patients in hospitals of the Veterans Administration (VA) make available a unique opportunity to study survival rates of a large group. This study analyzes the survival experience of patients whose initial treatment in a VA hospital for trauma to the spinal cord occurred between Oct. 1, 1955, and Sept. 30, 1965. Life table methodology enabled survival rates to be calculated for various intervals after injury and allowed for maximum use of each patient's experience. Age at injury, level of lesion, and extent of paralysis were all found to be important factors in survival. High mortality occurs in the first three months regardless of age at injury or level of lesion. Of those paraplegic and quadriplegic patients who survived the first three months after injury, the ten-year survival rates are quite similar, 86% and 80%, respectively.

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Specialized Service
IN

PROFESSIONAL LIABILITY
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*is a high mark
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MEDICAL PROTECTIVE COMPANY
FORT WANE, INDIANA

Professional Protection Exclusively since 1899

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Irving R. Levine



"The Carter Administration— After 16 Months"

Jimmy Carter — Americo — What has happened in the last 16 months? Irving R. Levine, a news correspondent for NBC News, will share his observations of the Annual Distinguished Luncheon.

Levine is one of Americo's most experienced broadcast journalists. In the 24 years he has been on NBC News correspondent, he has reported and interpreted events on television and radio from four continents. Currently, he is Economic Affairs correspondent in Washington, D.C. Levine is the author of four books, has contributed articles to national magazines and is a frequent lecturer. Prior to his current assignment in the nation's capitol, he was based as NBC News correspondent for 10 years in Rome, four years in Moscow, two years in Tokyo, and a year in London.

Annual Distinguished Luncheon

12:00 Noon

Wednesday, May 3

Registration Forms for the Session and Ticket Forms will be distributed in early April

Bacterial Contamination and Transmission by Nitrous Oxide Sedation Apparatus — L. M. Hunt (Emory Univ School of Dentistry, Atlanta, GA 30322) and J. A. Yagiela *Oral Surg* 44:367-372 (Sept) 1977.

Microbial contamination of sterile nasal hoods was found in nine of 21 clinical administrations of nitrous oxide-oxygen conscious sedation. In each case, bacteria isolated from the hood after 30 minutes' use were correlated morphologically with organisms recovered from the subject's nasal mucosa. A laboratory investigation using an artificial respiration-sedation system revealed a significant possibility of cross-infection between patients when improperly disinfected sedation equipment is used.

Relationships Between Child-Rearing Styles and Child Behavior Over Time — R. W. Chamberlin (Dept of Pediatrics, Univ of Rochester, Rochester, NY 14642) *Am J Dis Child* 132:155-160, (Feb) 1978.

The hypothesis that "authoritarian" style of child rearing will lead to more home and school problems than will "accommodative" styles was investigated. In 135 children who were followed up from age 2 years into first grade, observations showed no important differences between groups on any of the scores indicating malfunctioning for boys and girls at home or school. However, the home behavior of boys being raised with accommodative styles was described in more positive terms by their mothers than those raised with authoritarian styles. The accommodatively raised girls were described in more positive terms by their first grade teachers. There was no evidence in this study that the permissive style is producing large numbers of "spoiled brats" nor that the authoritarian styles are producing large numbers of overly aggressive or inhibited children. The way parents handle authority relationships is not sufficiently predictive of later problems to warrant any widespread attempts by physicians to change them. The physician should respect individual differences in child-rearing style and only intervene where there is substantial evidence that a particular approach is having a harmful effect.

**Brief Summary of Prescribing Information
Combined TEGOPEN[®] (cloxacillin sodium)
Capsules and Oral Solution**

For complete information, consult Official Package Circular. (12) TEGOPEN 9 11/75

Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriology studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

Usual Dosage: Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

Supplied: Capsules — 250 mg. in bottles of 100, 500 mg. in bottles of 100. Oral Solution — 125 mg., 5 ml. in 100 ml. and 200 ml. bottles.

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IN THE OMAHA AREA, STAPH RESISTANCE HAS NOW REACHED 82%*

resistance to penicillin G among community-acquired staph infections. Data on file, Bristol Laboratories.

WHEN YOU CAN'T RULE OUT STAPH, CONSIDER

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- Effective against nonpenicillinase-producing staphylococci, beta-hemolytic streptococci, and pneumococci.†

†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *in vitro* data is unknown.

- 10 times more active against strep than staph.
- Well absorbed from the G.I. tract.‡

‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.



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Surgical vs Medical Treatment in Disease of Left Main Coronary Artery — A. Oberman et al (Seventh Floor Medical Towers Bldg, 1717 11th Ave S, Birmingham, AL 35294) Lancet 2:591-593 (Sept 18) 1976.

Data from 179 patients with a significant lesion of the left main coronary artery were reviewed to compare survival with and without bypass graft surgery. One hundred forty-nine patients were treated with bypass grafting. Of 38 patients treated medically, 24 were suitable for surgery but either had been evaluated before the widespread use of bypass grafting procedures or preferred medical treatment. Major prognostic factors in this group were comparable to the surgical patients. The survival rate was consistently higher for the surgically treated group and differed significantly ($P < .02$) for the total duration of followup. At 12 months, 89% of the surgical group were alive, but only 73% of the comparable medical group; at 24 months, survival rates were 86% and 65%, respectively.

"Fun Night"
Tuesday, May 2
The Humor and Wit of
Mark Russell

Mark Russell has been called many things, from a political satirist to just plain crazy. One thing is for sure, his special kind of political humor makes him a very funny man.

A performer with no particular political axe to grind ("I'm a confused independent," he says, "but I can be bought") he has been zinging Democrats and Republicans from Washington nightclubs since the days of the New Frontier. Russell's background includes engagements at some of America's top night spots and four record albums. He has often been a guest on many television shows, including The Tonight Show, Merv Griffin Show, Today Show, two David Frost Specials, a BBC special and five live one-man specials for the Public Broadcasting System. His syndicated column with the Los Angeles Times goes to over 100 newspapers.



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NMA 110th Annual Session

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Specialty: _____ **Telephone:** (_____) _____

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The Coin Lesion Story: Update 1976 — J. F. Ray III et al (Marshfield Clinic, Marshfield, WI 54449) Chest 70:332-336 (Sept) 1976.

The authors reviewed 179 patients who had undergone thoracotomy and resection of a suspected malignant coin lesion of the lung over the past 20 years to see if a policy of early thoracotomy was therapeutically valid. The average diameter of all lesions was 1.6 cm; the average diameter of 27 malignant lesions (15%) was 1.8 cm. Follow-up of the 27 patients with malignant neoplasms was 100%. The present survival rate of the 19 patients with primary lung cancer is 89% (17/19). Of 12 cases of primary lung cancer followed for five years, ten (83%) survived. The five-year survival of the eight patients with metastatic lesions was 25% (2/8). There were no postoperative deaths and few serious postoperative complications (four patients or 2%). Very small primary lung cancers detected and treated early do not have the same poor prognosis as larger primary cancers.

a highlight of the NMA's 110th Annual Session . . .

SYMPOSIUM ON "What's New In Medicine"

"The Spectrum and Management of Hepatitis B"

"Update on Cimetidine — H₂ Antagonist"

Rowen K. Zetterman, M.D., Omaha
Gastroenterology — Internal Medicine

"Complimentary Uses of Newer Images, Nuclear, C.T. and Ultrasound"

Lawrence R. James, M.D., Omaha — Radiology

Athletic Medicine

"Knee Arthroscopy, Rehabilitation and Cy-Bex Demonstration"

Patrick E. Clare, M.D., Lincoln
Orthopedic Surgery

Charles W. Newman, M.D., Lincoln
Orthopedic Surgery

Jerry Weber, RPT and Assistant Trainer
University of Nebraska — Lincoln
Department of Athletics

Y. Scott Moore, M.D., Lincoln
Moderator

Wednesday, May 3
9:00-12:00 Noon

(Three Simultaneous Round-Table Discussions Scheduled in 50-Minute Segments.
10 Minutes Between Each Segment)

Kefzol[®] I.M./I.V. cefazolin sodium

Ampoules, equivalent to 500 mg., 1 Gm.,
and 10 Gm. of cefazolin

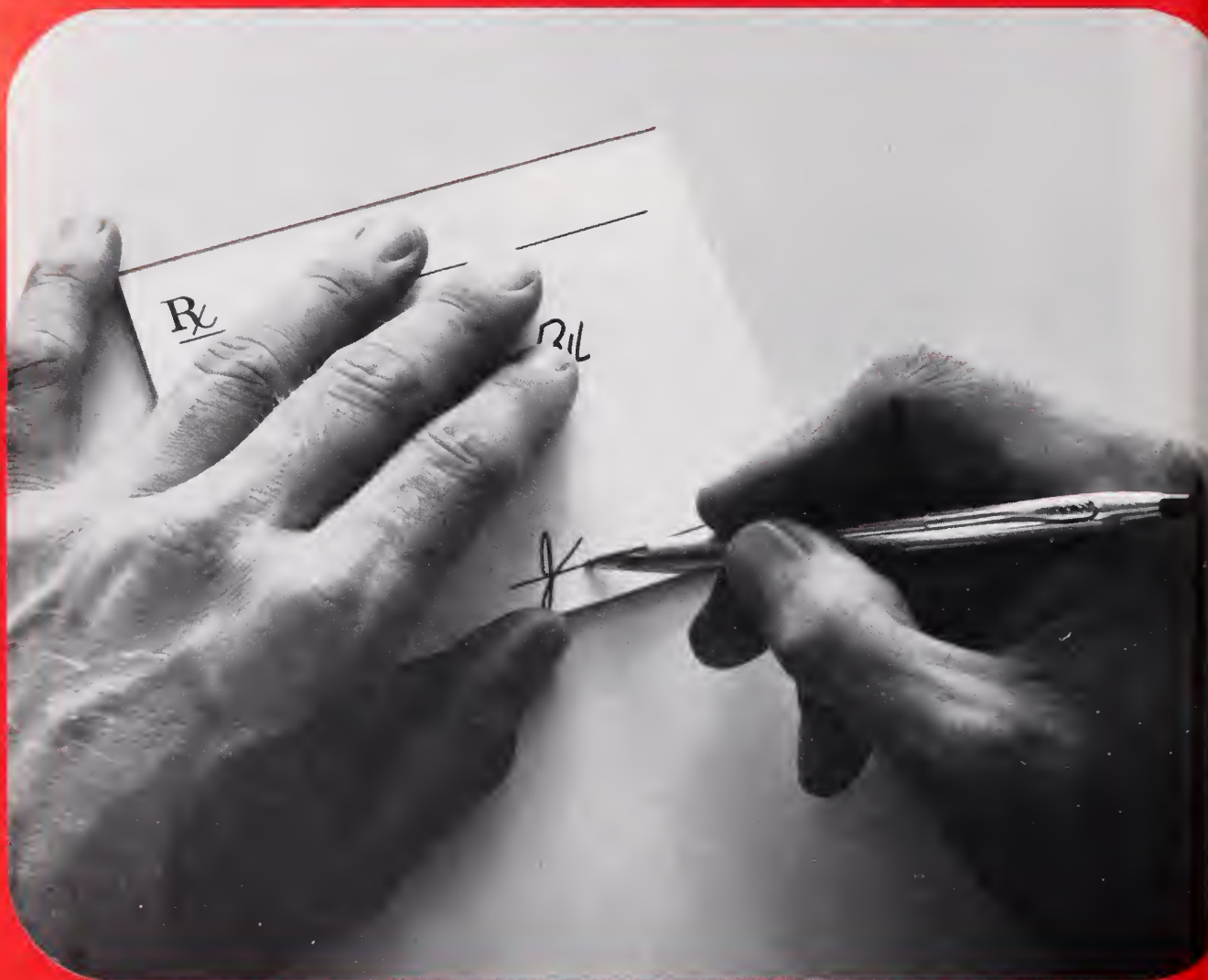


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Contraindications: Anuria, hypersensitivity to this or other sulfonamide-derived drugs.

Warnings: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy.

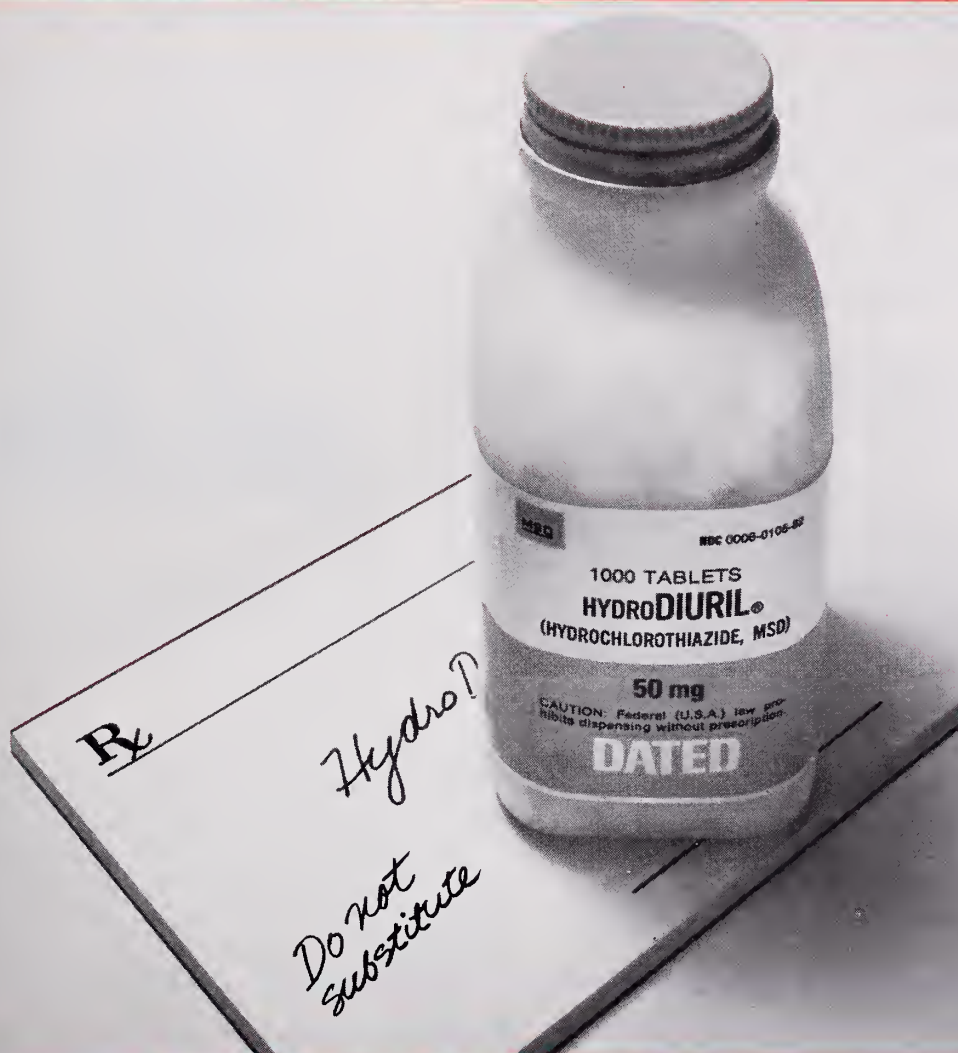
Use in Pregnancy: Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults.

Nursing Mothers: Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.

Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting ex-

cessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting. Hypokalemia may develop, especially with brisk diuresis in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, with inadequate oral electrolyte intake. Hypokalemia can sensitize and exaggerate response of heart to toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice. Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal in-

or experience—



or ours.

ment becomes evident, consider withholding or discontinuing
etic therapy. Thiazides may decrease serum PBI levels without
s of thyroid disturbance. Calcium excretion is decreased by
ides. Pathologic changes in the parathyroid gland with hyper-
emia and hypophosphatemia have been observed in a few patients
rolonged therapy; thiazides should be discontinued before testing
arathyroid function.

Adverse Reactions: *Gastrointestinal System*—Anorexia; gastric ir-
on; nausea; vomiting; cramping; diarrhea; constipation; jaundice
hepatic cholestatic jaundice); pancreatitis; sialadenitis.

Central Nervous System—Dizziness; vertigo; paresthesias; headache;
hopsia.

Hematologic—Leukopenia; agranulocytosis; thrombocytopenia;
stic anemia.

Cardiovascular—Orthostatic hypotension (may be aggravated by
hol, barbiturates, or narcotics).

Hypersensitivity—Purpura; photosensitivity; rash; urticaria; necrotizing
itis (vasculitis) (cutaneous vasculitis); fever; respiratory distress
uding pneumonitis; anaphylactic reactions.

Other—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm;
kness; restlessness; transient blurred vision.

enever adverse reactions are moderate or severe, thiazide dosage
uld be reduced or therapy withdrawn.

Precautions: When used with other antihypertensive drugs, careful observa-
s for changes in blood pressure must be made, especially during
al therapy. Dosage of other antihypertensive agents must be

reduced by at least 50 percent as soon as this drug is added to the
regimen. As blood pressure falls under the potentiating effect of this
agent, further reduction in dosage, or even discontinuation, of other
antihypertensive drugs may be necessary.

How Supplied: Tablets containing 25 mg hydrochlorothiazide each in
bottles of 100 and 1000 and single-unit packages of 100; Tablets con-
taining 50 mg hydrochlorothiazide each in bottles of 100, 1000, and
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Doctor Michael F. Boyer
Antarctic Support Forces, U.S. Navy

Born in southeastern Nebraska, Doctor Michael F. Boyer attended the U.S. Naval Academy at Annapolis, Maryland, and graduated in 1969. He did postgraduate work at U.C. Berkeley and obtained a M.S. in Engineering. He graduated from the University of Nebraska College of Medicine in 1975.

The past year he was the Senior Medical Officer for Operation DEEP FREEZE and the National Science Foundation's Antarctic Research Program. The job encompasses the entire scope of medical care from planning, funding, and ordering of supplies to their final utilization in the Antarctic Health Care system.



Tuesday Morning — May 2

South Platte Room — Questions & Discussion
Registration Forms for the Session and Ticket Forms
will be distributed in early April.

ADVICE TO AUTHORS

The Editor of this Journal assumes no responsibility for opinions and claims expressed in the articles published herein.

Manuscripts to be presented for publication in the JOURNAL should be typewritten, double-spaced, on one side only of firm (not onion skin or flimsy), standard letter size (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title-page should be shown the title of the article, the name (or names) of the author, his degree and other significant credits. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Illustrations should be numbered and their locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be black (India ink) on pure white. Photographs should be on glossy paper and a minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

Manuscripts (original, not a carbon) should be sent directly to the Editor at the Journal's address.

Letters to the Editor submitted for publication should be prepared as above, and must carry the notation: To be Published.

Manuscripts not accepted for publication will not be returned to the author.

Reprints should be ordered from the printer, Norfolk Printing Co., Inc., P. O. Box 278, Norfolk, Nehr. 68701.

Mortality Among Oral Contraceptive Users
— Royal College of General Practitioners,
Oral Contraceptive Study (C. R. Kay,
Royal College of General Practitioners,
Manchester Research Unit, Manchester,
England) Lancet 2:727-731 (Oct 8) 1977.

In a large prospective study carried out in the United Kingdom, the death rate from disease of the circulatory system in women who had used oral contraceptives was five times that of controls who had never used them; and the death rate in those who had taken the pill continuously for five years or more was ten times that of the controls. The excess deaths in oral contraceptive users were due to a wide range of vascular conditions. The total mortality in women who had ever used the pill was increased by 40%, and this was due to an increase in deaths from circulatory disease of one per 5,000 ever-users per year. The excess was substantially greater than the mortality from complications of pregnancy in the controls, and was double the death rate from accidents. The excess mortality increased with age, cigarette smoking, and duration of oral contraceptive use.

THE NEBRASKA MEDICAL JOURNAL

THE GENTLE ART OF PERSUASION

The television commercial and informed consent have much in common. The advertiser tells you how wonderful is his cereal or his automobile. The doctor says you need an operation. But on TV you are told of experiments that insult my intelligence, of tests performed by two companies where each is better than the other, and you are sung to.

The surgeon sits down and talks to the patient simply and candidly. It was said that the patient is no more entitled to all the truth than he is to all the medicines in your saddle-bag. But we do not have saddle-bags now, and we tell the patient what he should know, and then much more, and consent becomes informed consent.

Meanwhile, I wonder if people who watch television are as untelligent as TV advertising seems to suggest; I think they cannot possibly be influenced by the silly advertising I see on my screen when the ad comes on and I leave the room or change channels. But if people are reasonably bright, they will not go out and buy things because the interviewer asks why do you prefer our brand and the interviewee says I just do, over and over again; in which case the advertisers are not as smart as the people.

I cannot imagine why advertisers do not simply say our product is better and then say why; that might influence me. But I will not buy something because somebody sings to me, or because six or eight unlovely characters dance frantically.

If I operate, the surgeon says, we can expect this to happen, and if you do not have the operation, these other things will come about. No singing, no dancing, and no unbelievable experiments. There is only one thing worse than the singing commercial, and that is when the singers dance.

—F.C.

NOT ENOUGH AND TOO MUCH

The physical examination is a one-of-a-kind phenomenon peculiar to the practice of medicine, and the report of the examination is as well unique. It is too often lopsided as a camel, with too much sticking out here, and great empty spaces where things the reader would very much like to know are simply left out.

The patient is so often obese or malnourished. It is a simple matter to weigh him and to put it in the report. We should know if the patient was clothed or not, and the height ought to appear.

I have seen reports where the patient was said to have tachycardia, and no pulse rate was given; or to be hypertensive without putting down the blood pressure. And how can we justify a report of an examination of a patient who has emphysema, when the respiratory rate is not given, or the words *poor vision* without supplying the patient's visual acuity?

I have observed that the hematocrit is usually three times the hemoglobin, and I suggest that hematocrit and hemoglobin tell you the same thing. If this is so, there seems to be no need for two tests when one will do.

Physical reports often ramble, and I have noticed that the longer the report, the less it tells you. They often include pages of laboratory tests, when the tests are already affixed to the report, so that you must read them twice.

There are two more things: sign your name so it can be read; and put the date in the report. Illegible signatures do not impress readers, they serve only to dismay and to irritate, since it is often important to know who did the examination and who it is you want to talk to. The date is important for obvious reasons, and July fourth should be written 7/4, and not 4/7 or better, July 4th; the year must be written down too, and the one word Wednesday tells us nothing. Neither does an eight-page report or a three-line holograph that cannot be read.

—F.C.

WHERE IS GOODNESS?

We do not know where thoughts begin, but they start *somewhere*. We cannot find intelligence when we look at a brain, but it is there.

Newton and Einstein were smarter than most of us; were their brains bigger, or were they better developed?

Lincoln and Schweitzer were nicer-than-average people; where did it show in their brains; is there a goodness center?

Are there kindness cells?

Where is fancy bred?

—F.C.

ON GETTING WELL

This is what our everyday activities are all about: getting people well. We have found that some things promote healing, relieve pain, and prolong life. But what about biofeedback and placebo; what of the role of the mind in organic disease, and what about the will to live? I refer you to three articles that are more than a little upsetting; they are downright provocative.

The first is written by a patient in whom a diagnosis of ankylosing spondylitis was made who felt that a hospital was no place for a person who was seriously ill, who took part

in his treatment and who got well. And nearly-locking of the jaws and subcutaneous nodules were not imaginary symptoms.

The second article was written by another patient, who was himself a physician. He went from one little sign to ten big symptoms while taking, at different times, eight different drugs; and he left a scheduled kidney scan when he overheard technicians making decimal mistakes.

The third deals with the entire subject of the placebo. In all three, the rationale of taking medicine is held up to strong light. In various parts of all three, the power of suggestion is emphasized, as is the ability of the brain to heal, the authority of the desire to live, and the danger of administering large doses of drugs.

Can you get yourself well by wanting to be well? Should we give placebos and not tell the patient? Is much of what we are doing wrong? We have known something about the mind and the body for a long time, but read these things. They are disturbing, but they must be read. We may not like to think that we are not as wise as we thought we were or that we must relearn much about the body, but it will not hurt us to be shocked and to read, even reluctantly.

—F.C.

Arteriovenous Malformation of the Uterus

A case of arteriovenous malformation is reported. The etiology is not known. The symptoms are profuse vaginal bleeding. The uterus is usually symmetrically enlarged and soft; pulsation and thrill may be palpable in the vaginal fornices. Dilation and curettage is dangerous with arteriovenous malformation of the uterus because of a greater danger of hemorrhage. Treatment is abdominal hysterectomy.

Arteriovenous malformations, a rare entity, are potentially lethal because of profuse, uncontrollable bleeding, often associated with diagnostic dilation and curettage in such patients.

Case Report —

The patient, a 41 year old white female, gravida 8, para 5, abortio 3, entered Archbishop Bergan Mercy Hospital on July 9, 1976 with intermittent uterine bleeding, occasionally profuse. Following uneventful menopause two and one half years prior to admission, she experienced painless vaginal bleeding in late May for seven days, requiring two to three pads per day. Pelvic examination, Papanicolaou smear, and hematocrit were normal. She declined the recommended dilation and curettage, but experienced fatigue, hot and cold flashes the following ten weeks. Recurrent vaginal bleeding with cramping pelvic pain brought the patient to the hospital for diagnostic evaluation.

Menstrual History —

Menarche occurred at 14 years with interval duration of five days with mild dysmenorrhea. At ages 26 and 29 she underwent dilation and curettage for menorrhagia. Menometrorrhagia persisted intermittently, and did not respond to three month trial of oral contraceptives. Intra-uterine devices were never used. Menses scanty in 1972, ceased in September, 1973. Hot and cold flashes were present during 1975.

ROBERT C. OLESH, M.D. and

JOHN F. FITZGIBBONS, M.D.

Department of Obstetrics and Gynecology
Creighton University School of Medicine and
The Department of Pathology
Archbishop Bergan Mercy Hospital
Omaha, Nebraska

The fourth and fifth pregnancies at 31 and 33 years of age terminated normally, but were associated with heavy postpartum hemorrhage, conservative non-operative management. At 36, her sixth pregnancy resulted in a fetal death at 29 weeks, associated with premature rupture of the membranes, terminal abruptio placenta, marginal sinus rupture, and circumvallate placenta. Her seventh and eighth pregnancies at 37 and 39 years resulted in spontaneous abortion at nine to ten and seven to eight weeks. Dilation and curettage, uneventful after the first abortion, was associated with uterine hemorrhage the last time which responded to oxytocic administration. A roughened posterior left uterine endometrial surface was noted at curettage.

Past Medical History —

Usual childhood illnesses. Gynecologic surgery included three cryotherapy treatments for cervical actropion and previously noted dilations and curettages. Patient is generally in good health, but has had occasional cystitis. There is no history of previous blood transfusions.

Family History —

The patient's sister became amenorrheic at age 32 with no subsequent gynecologic abnormalities. Her daughter at 11 years of age had severe menometrorrhagia and dysmenorrhea with her second menses. With a hemoglobin of 5 gm%. D&C controlled the uterine bleeding as she received 4 units of blood. The uterus was twice normal size and the endometrium was hyperplastic.

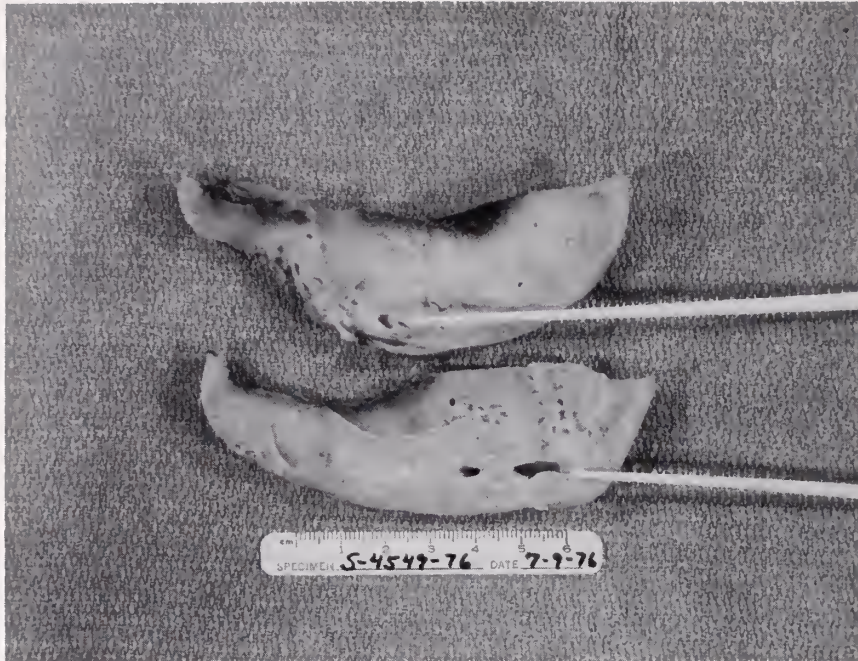


Figure 1

Sagittal sections of the uterus. Large, irregular, tortuous vascular channels are indicated by the pointers. Note several of the channels approaching the endometrial surface in the lower segment.

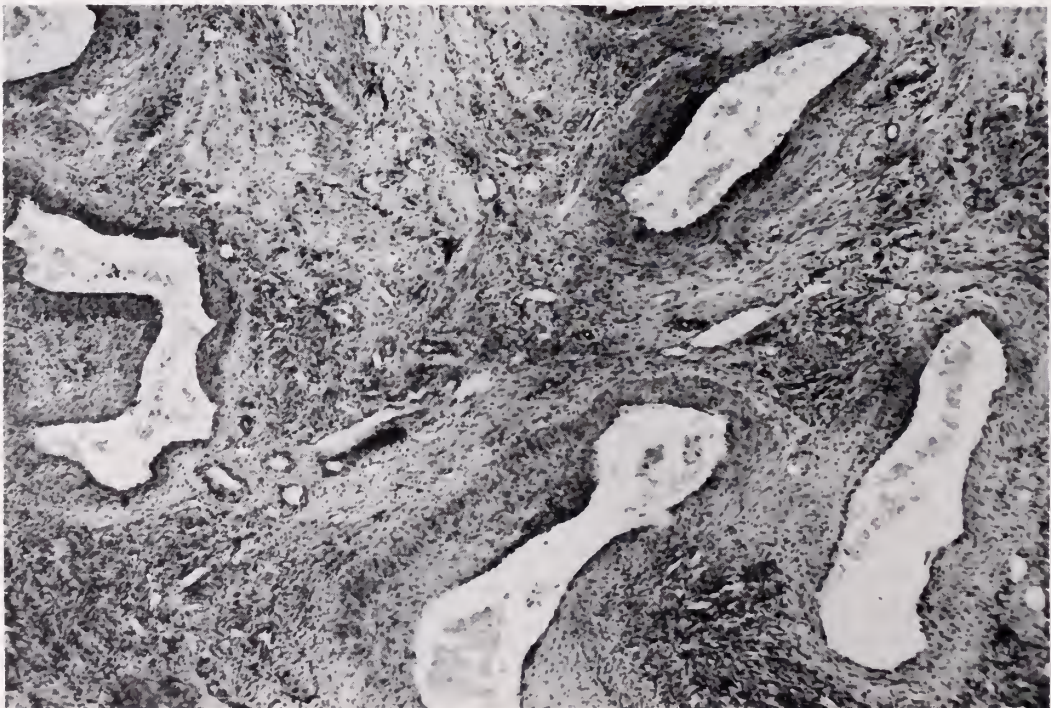


Figure 2

A low-power view showing several vascular channels. An arterio-venous communication is suggested by the incomplete smooth muscle wall of the channel in the low midline of the figure. H & E X 40.

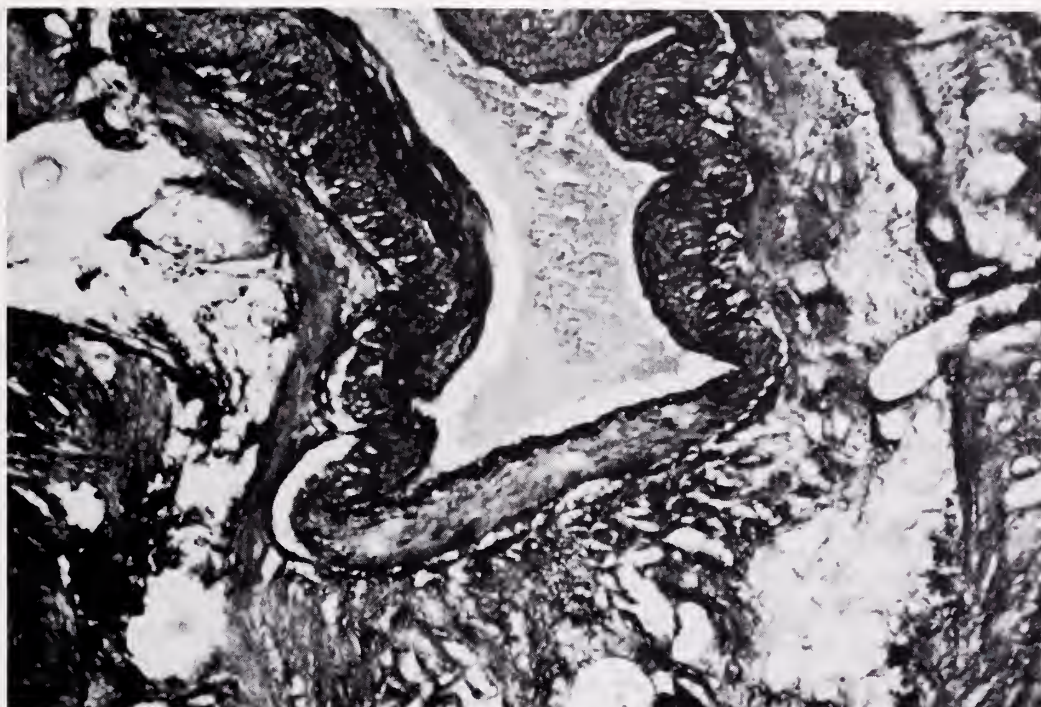


Figure 3
Fibrous intimal thickening is seen above the internal elastic lamina in this arterial structure. Elastic tissue stain X 100.

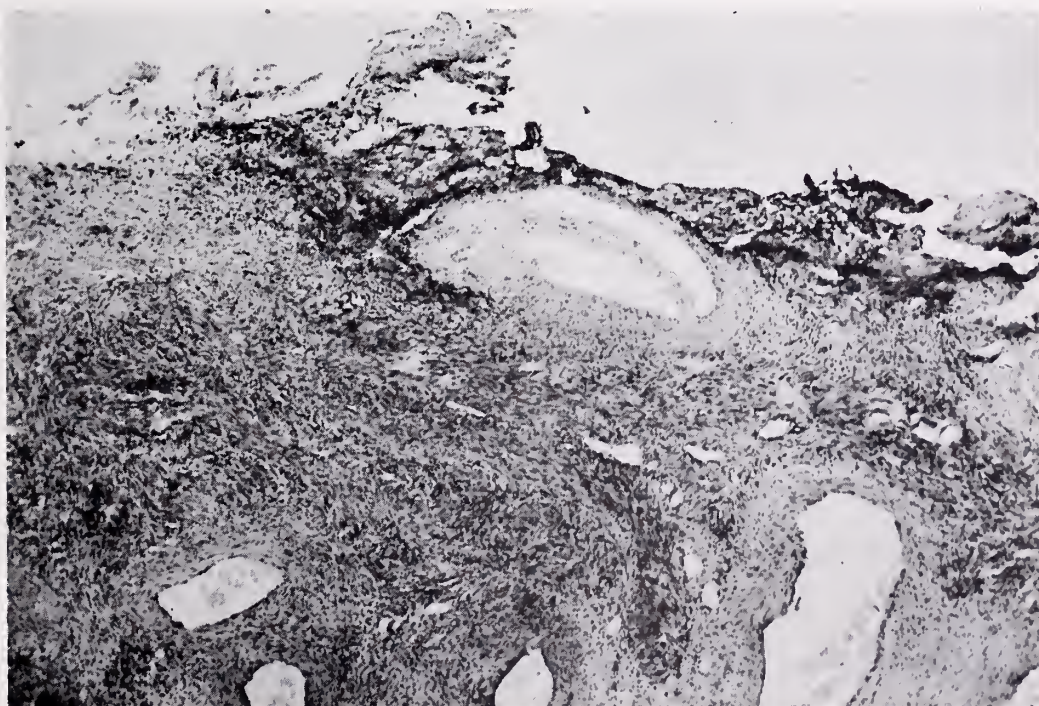


Figure 4
A low power view of the curetted surface of the endometrium with large subadjacent vascular channels present. H & E X 40.

Physical Exam —

Inspection revealed a well-developed, well-nourished, oriented 41 year old white female. Blood pressure 124/70. HEENT was within normal limits. Thyroid was nonpalpable, breasts had no nodules or nodes palpable, heart and lungs normal, abdomen normal, uterus was anterior, twice normal size, soft, boggy and freely moveable. There were no abnormal adnexal findings. The CBC showed 12.3 g hemoglobin, hematocrit of 35.0, with normal indices, normal differential, and adequate platelets.

Operative Report —

On July 9, 1976, patient was scheduled for dilation and curettage. The cervix was dilated with Goodell dilators. Depth was 10-11 cm. Polyp forceps did not extract any tissue. Sharp curetting produced numerous fragments of old, clotted blood. The posterior surface of the uterus was noted to be extremely roughened. With continued curettement, the bleeding became more profuse. Ten units of Syntocinon was added to the IV without restoration of normal uterine tone. Because of the persistent profuse bleeding, emergency abdominal hysterectomy was begun. Direct examination revealed the uterus twice normal size, extremely boggy and non-contractile with manual stimulation. At this time, the impression was missed abortion because of the suggestive pregnancy changes and the atonic uterus. 30 ml of blood was in the cul-de-sac, apparently expelled through the tubes from the intrauterine cavity. The adnexa appeared normal. Blood loss estimated was 2500 ml. The patient received 500 ml of albumin and 1 unit of whole blood during surgery in addition to lactated Ringers solution. During surgery, vital signs were stable and urine output adequate. Postoperatively, the patient received three units of whole blood and two units of packed cells. She was discharged after a nine day hospitalization.

Gross Pathology —

The specimen submitted to the pathology laboratory consisted of a uterus with cervix weighing 320 gms. It measures 13 x 8.5 x 6.5 cm. The outer surface was smooth, but on palpation the tissue had a boggy, flabby

consistency. The cervix measures 4 x 4 x 3.5 cm. The lips were pink and smooth. The cervical os was ovoid and somewhat gaping, and small amounts of blood were found at the cervical os. On sectioning the uterus, the endometrial cavity was somewhat enlarged, and contained moderate amounts of clotted blood. On removal of the blood, the endometrial surface was irregular, reddened, and slightly ragged in appearance. The endocervix also contained small amounts of clotted blood in the canal which, on removal, revealed a reddened surface. Multiple sectioning through the myometrium showed a thickness up to 3.5 cm. This thickened portion was mostly in the posterior wall of the fundus. Striking vascular dilations were seen on the cut surfaces of the myometrium. Many of these were quite tortuous and irregular in appearance, and suggested blood sinuses. The vascular spaces measured up to a centimeter in widest diameter, and a few would admit the tip of the little finger. The spaces were seen to extend upward to the endometrial surface in several areas.

Microscopic Examination —

Multiple sections of the myometrium showed numerous enlarged vascular spaces. These were tortuous and irregular in their courses. Some of these showed thick, smooth muscle walls, consistent with arterial structures while others contained little smooth muscle, and had the appearance of venous channels. Elastic tissue stains of the arterial vessels showed some to have well-defined internal elastic lamina. In several areas there appeared to be junctions joining both types of vessels. Intimal thickening by fibrous tissue was seen in both arterial and venous structures. In several of these vessels this took the appearance of nodular plaque-like thickenings. Several sections showed the vascular channels to be very close to the endometrial surface and, indeed, in one or two areas, the walls of these channels had been nearly completely curetted away and almost opened into the endometrial cavity. Trichrome stains of the myometrium showed increased amounts of fibrous tissue between and surrounding muscle bundles.

Discussion —

Arteriovenous malformations have been described using many different terms: an-

eurysm, cirroid aneurysm, arteriectasia, and A-V fistula. The etiology of A-V malformation of the uterus is unknown. Suspicious are arteriosclerosis in most post-menopausal patients, pregnancy causing increased vessel size, congenital, or traumatic (wounds or previous pelvic surgery). Most patients reported did not have previous pelvic surgery. There appears to be a relationship between A-V malformation and trophoblastic disease. During pregnancy, a temporary A-V shunt is present at the placenta with dilation of sinuses in the placenta. These communications between the villae in the placenta contain irregular and bizarre vessels. Differentiation of menorrhagia secondary to A-V malformation or a highly vascular tumor, such as hemangioma or hamartoma is difficult.

Most patients reported with A-V malformation that require total abdominal hysterectomy, secondary to profuse uterine bleeding causing anemia are over 50 years, multigravida, never had postpartum complications, had spontaneous abortions and are postmenopausal. On physical exam, there may be audible continuous systolic murmurs and thrills over the pelvis and a palpable pulsation and thrills in the fornices. A systolic murmur radiating to the neck and increased frequency of headaches have been reported. These may be cardiac enlargement, increased cardiac output and increased blood volume, all signs of congestive heart failure. Pregnancy should be excluded as the uterus is enlarged, soft, and spongy.

Preoperative confirmation of A-V malformation would be possible with arteriography using dye dilution techniques. This would show convoluted vessels and dilated vessels in the broad ligament.

D&C or other instrumentation of the uterus is contraindicated when A-V malformations are known. After dilation, a large amount of clots are removed from the uterus and after curettage, profuse bleeding begins. If known, the operating room personnel should be prepared for emergency hysterectomy or internal iliac ligation temporarily, and blood should be ready for transfusions. When abdominal hysterectomy is performed, usually many engorged vessels are seen and hemostasis may be difficult. Most of the pathology reported shows hypertrophic and dilated vessels with A-V malformations which were heavily walled. The myometrium was fibrotic. 50% of the patients post-operatively did well and 50% had major complications. Our case presentation is indeed unusual in that the patient is only 41 years, but possibly was menopausal two and a half years prior to this report. Post-operative secondary hemorrhage or retroperitoneal ooze is not unlikely because of the dilated vessels and re-exploration may be needed to control the bleeding vessels.

The authors wish to thank Hilaire H. Doolittle, M.D. for permission to report this case, and R. J. Luby, M.D. for review of this paper.

Health Behavior of Children — A Predictor of the Nation's Health?

Part I

HOW healthy are Americans? "Health, United States, 1975," a three volume study by the Department of Health, Education and Welfare, indicated that while the physical condition of Americans has improved in the past generation, the major causes of disease today are due to life style patterns of excessive use of alcohol, tobacco, improper diet, obesity, and lack of exercise.¹ This report suggests that further improvement in health status will come primarily by individual action. A recent report of the Senate Subcommittee on Health stated that improvement in the health of the American people has not improved in proportion to the growing investment.²

Life style is said to be the major national health problem of our time and efforts to improve the nation's health must focus on changing health behavior. No increase in quality or amount of "the health care delivery" system can ever hope to ameliorate or rehabilitate these adverse health affects.^{3,4,5,6} The era of the "health care delivery" system has been with us for over a decade, with the sycophants from every side giving their prescriptions, beginning with PL 89-93 (the Medicare Law) to PEER review of HMOs. Much of the present concern has been motivated by the commitment to health care as a right, and if we could improve the system, good health will follow. The system worked well in the 1930s through the 1950s when infectious diseases such as polio were brought under control. Simultaneously, during this period of time the medical center became the brightest star in the health constellation. But this model does not fit the "life style" problems. We must look at areas outside the medical center, improving the environment, reducing accidents and behavioral motivation for healthful living practices. Much as we may reluctantly leave the "medical center" and all its modern "miracles," this we must do if we are to improve

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health status. There are no clear paths or beacons and perhaps this explains our reluctance to leave the security blanket of the medical center. In addition, as physicians we lose our aura and mystique — we swim in uncertain waters.

The greatest potential for improving health is said to be "the ways of healthful living" — the era of Hygeia and we must relearn the lessons of past generations whose key to health in the pre-World War II era was hygeia. There are no potent medications, instant vaccines, or immunizations, or no technological instruments that can prevent or reduce the ravages and debilitation or unhealthful ways of living. The apocalypse of old — death, disease, pestilence, and famine have been replaced by cardiovascular disease, malignancy, accidents, obesity, pollution, and drug problems.

Prevention through knowledge and practice is a major component in any health system, but in the frequent "cost containment studies" it is all too frequently neglected or denied. Health education is of vital importance but factual knowledge may not influence behavior, i.e. smoking and the long struggle to get public water supplies fluoridated.

On July 30, 1975 the Senate passed a Disease Control Act that includes a Title to increase consumer health education, and to establish The Office of Consumer Health Education. Health education has suddenly become popular and now is an integral component of health planning programs. The danger is that the dollars allocated plus simplistic approaches to complex behavioral problems will disregard behavioral science input and health education principles. In-

dividual responsibility is being zeroed in on as the main focus for change. Despite a sea of temptations plus an unhealthy environment emerges the exhortation — "you can do it" surrounded by advertising for unsafe and unhealthy practices and products in a complex, fragmented and interdependent social milieu. How the social conceptual issue is interdigitated with individual effort will have tremendous implications for those efforts selected to improve health behavior.

Health education for children is something that everybody feels is important. It is quite difficult, on the otherhand, to determine what should be taught as part of that health education. Vacalis et al reported on a Nebraska study of rank order of various health items comparing physicians and teachers.⁷ Physicians and teachers agreed on 9 items. However, in 17 items there were marked differences between the two groups. The lack of communication between physicians and teachers as to what were the most important items to be included in a health education curriculum were most obvious, and perhaps most difficult of all to assess how successful the education system is in teaching health behavior concepts to children. The physicians were most concerned about the types of health insurance, differences in medical specialties and sources of health information. The teachers, in contrast, were most concerned about health department services, how to evaluate medical services and private physicians fee schedules in addition to free clinics. There is a limited amount of time in each classroom. If the subjects taught are not agreed upon, or the ones selected by the physicians to be the most important one of two results will ensue: lack of support or mistrust by the physician for the health education program, or the physician will have false expectations of future patients' understanding of the system and increase the probability for unsatisfactory patient-doctor relationships. The "better education consumer" will be unlikely if lack of communication continues to exist between teachers and physicians. As physicians we must discuss the health education programs as we shall have a long time to live with the "health education" system. A recent study by Newman and Fuenning of Nebraska

high school students concerning adolescent health knowledge revealed that males do not equal or surpass the national average in any area and females scored only slightly higher in dental health and nutrition.⁸ Misconceptions and misunderstandings were appalling. For example, one third of the students believed media advertisement of health products were factual because legislation guaranteed it. Overall, the sample of Nebraska high school students had less knowledge than the national sampling. A more recent study by Newman et al^{9,10} in 1975 tested 1,148 eighth grade students using Form 3-A of the AAHPER Cooperative Health Education Test.¹⁰ In this study scores were higher than the national scores and students who had received separate health education classes scored higher in personal health, mental health and sex education.

One of the chief priorities listed by the Health Planning Council of the Midlands, now the Health Service Agency, is to determine how well health education is implemented. The Health Planning Council of the Midlands (HPCM) during the past year completed the Area Wide Plan. There were four task forces. All of the task forces listed health education and information as a major priority. The problem was clearly stated — no community comprehensive health education program exists; the solution — model for health education; recommendation for action — assist in development of a health education model. The HPCM and the Division of Community Pediatrics of the Creighton University School of Medicine then held a series of meetings with the school administrators to explore how best to ascertain the school aged child's health behavior.

The biggest obstacle to such an undertaking was to find a health behavior inventory test that was standardized, simple to administer, and pertinent to this present day. A review of the major compendiums on testing of children showed there to be very few grade school health inventory tests. After a lengthy search for such a valid test, it was decided to use the Health Behavior Inventory devised by Sylvia Yellen in the late 1950s.¹¹

The Health Behavior Inventory (HBI) is designed to measure what a pupil actually does and not what he thinks he should do. It hopefully is a measure of reality and not idealism. The original intention of the test was to help teachers and curriculum planners to know and to meet the student's needs in health behavior. Other objectives are to show the health behavior of elementary students and to recognize any health problems needing attention.

The inventory is composed of 40 picture-questions. Each question is followed by three answer choices to choose between: 1) "Most of the time I do," 2) "Sometimes I do," 3) "No, I never do." The health inventory is subdivided into eight areas. The eight areas included Personal Health (8 items), Personal Cleanliness (7 items), Nutrition (7 items), Safety (5 items), Community Health (5 items), Infection and Disease (11 items), Mental Health (4 items), and Dental Health (3 items). The test can be administered over the span of 30 minutes or less although no time limit is placed on the test because to properly interpret the Health Behavior Inventory a response to all items is essential.

Norms have been well established with the Health Behavior Inventory for grades 3-6. After several conferences with school educators, it was believed that fourth grade students would be the best to test since they would be more mature than third graders and yet not so mature as to give silly answers to the test questions that sixth graders might possibly do.

After finally securing what was agreed to be the best test in the realm of health education the various school curriculum administrators were contacted in the greater Omaha area. During the subsequent meetings with these administrators new obstacles to performing this test in school became apparent.

1. Some of the educators were afraid parents might interpret such a test as an invasion of personal affairs.
2. Others felt that the test should not be given to anyone without the direct consent of parents being granted beforehand.
3. There was great debate as to what the value of such a test would be to the various school districts anyway.
4. Less than whole-hearted support by the school administrators was probably due to the fact that any comparison between one discipline by another is bound to create an atmosphere of uncertainty on the part of that discipline being examined, or to compare one school district with another.

It was hoped that by the administration of the Health Behavior Inventory to a representative group of children in the fourth grade of the greater Omaha school systems that a small niche could be made in understanding how health behavior is practiced. If nothing else it represented a big step forward in getting members of the education and medical professions plus the Health Service Agency to work together on a common task. Although it was agreed that "health care of the school child remains the primary responsibility of the parents,"¹² it was also clear that the school system can be instrumental in identifying and coordinating the teaching of specific health problems such as personal health, safety, etc.

This study also showed that the area of testing health behavior in children is in many ways still a virgin field. Many more tests were available for the testing of adolescent and junior high students than for the testing of grade school children.^{13, 14, 15} It was also clear that many other professionals across the country were also anxious to hear the results of this study.

Staging of Hodgkin's Disease

Diagnostic Organization

STAGING of Hodgkin's Disease: diagnostic organization. "It is not error which opposes the progress of truth: it is indolence, obstinancy, the spirit of routine and everything which favors inaction" — Turgot

The history of medical knowledge concerning Hodgkin's disease provides significant insight into the development of current care. Thomas Hodgkin first reported the "morbid appearance of the absorbent glands and spleen" in 1832.¹ Sternberg described "peculiar cells with outstanding nucleoli" in 1898 and Reed later confirmed these findings. At that time, the disease was classified as Stage I, lymph node enlargement, and Stage II, generalized cachexia. Multiple revisions in this classification have been proposed as lesions of Hodgkin's disease have been discovered in specific areas of the body. (Table 1).^{2,3} Originally, categorization of the disease served to predict prognosis. More recently, favorable results in treatment with combinations of radiotherapy and chemotherapy have been abetted by a staging operation.

TABLE 1
HODGKIN'S DISEASE STAGES

Stage I	— One Anatomic Area
Stage II	— Two or More Anatomic Regions On Same Side of Diaphragm
Stage III	— Anatomic Regions on Both Sides of Diaphragm
Stage IV	— Diffuse or Disseminated Involvement of One or More Extralymphatic Organs of Tissues

MATERIALS AND METHODS

From January 1, 1971 to September 8, 1976, we saw 121 individuals with Hodgkin's disease. Staging procedures were carried out on 32 patients. The extent of their disease could not be securely defined by x-ray, nuclear scan, retroperitoneal lymphangiograms and bone biopsy before operation. Ages ranged from 6 to 69 in the 11 women

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and 21 men. The median age was 23 years. The median duration of the disease before staging was one month; however, known disease had existed for from one week to four years. Symptoms included fever, sweats, cutaneous infection, weight loss, and fatigue. The initial areas in which diseased lymph tissues were biopsied included the cervical chain in 18 patients, supraclavicular region in nine, spleen in two, axillary group in two, and inguinal region in one.

Lymphangiograms were obtained in 29 patients with 18 positive reports. Splenic involvement was suspected in seven patients following clinical evaluation. Preoperative evaluation placed the patients into clinical stages based upon history, physical examination, retroperitoneal lymphangiogram, selected liver-spleen scan and lymph node biopsy.

The staging operation consisted of celiotomy with splenectomy, liver biopsy by the cork borer technique, and periaortic lymph node biopsy at the level of the second and third lumbar vertebrae.⁴ Metal clips were employed to outline the areas of dissection. Bone biopsy and specific lymph node biopsy from other regions were carried out on selected patients, when indicated by preoperative evaluation.

RESULTS

The clinical stage of the disease was changed by the results of operation in 19 of

32 patients (Table 2). Correlation of lymphangiograms and operative findings demonstrated 34% false positive and 7% false negative lymphangiograms. Of the 32 spleens removed, 15 showed histologic evidence of disease. Three spleens suspected of harboring Hodgkin's disease preoperatively proved to be free from disease. Nine clinically normal spleens were proved to contain the disease after staging.

TABLE 2
CLASSIFICATION CHANGES

Estimate Before Operation	Actual After Operation	Patients
Stage I	Non-Hodgkin's Lymphadenopathy	1
Stage I	Stage III	3
Stage II	Stage III	2
Stage II	Stage IV	3
Stage III	Stage IV	8
Stage III	Stage I	1
Stage III	Stage II	1

TABLE 3
STAGE AND HISTOLOGIC TYPE

Stage	Histologic Type	Patients
I	Non-Hodgkin's Lymphadenopathy	1
	Mixed	4
II	Lymphocyte Predominant	6
	Nodular Sclerosis	1
III	Nodular Sclerosis	1
	Mixed	4
	Lymphocyte Depletion	1
	Unclassified	2
IV	Lymphocyte Predominant	2
	Nodular Sclerosis	3
	Mixed	4
	Lymphocyte Depletion	2
	Unclassified	1
Total		32

There were seven complications in 32 operations. Complications, both early and late, included atelectasis, pneumonitis, myocardial infarction, wound infection, and wound disruption. Nine patients have died of their disease. One patient died 30 days after operation from a myocardial infarction. Twenty-two patients remain alive. Sixteen are in remission and six have relapsed, requiring a change of therapy. After operation, all patients were placed in specific stages and 28 were classified by cell type (Table 3). The cell type remains unclassified in four patients.

DISCUSSION

Categorization of Hodgkin's disease by operative staging has become a valuable tool. This maneuver has erased the whimsy and empiricism of a treatment program based on clinical staging alone. The spleen is one of the first abdominal organs to which Hodgkin's disease spreads.⁵ This study emphasized that the accurate assessment of splenic involvement was not possible without operation. The preoperative clinical evaluation of the existence of splenic involvement was 63% correct, a finding similar to reports of others.⁶ The accuracy of staging was improved as a result of operation in 59% of the patients. All of the reclassified patients received beneficial changes in treatment plans. Similar data have been reported by Kaplan and others.^{7, 8, 9, 10} Radiotherapy was used for Stages I thru III and chemotherapy for Stage IV. Selected patients with Stage III disease also received chemotherapy.

A dividend of more accurate staging has been improved definitions of remission and relapse. Thus, changes in base line parameters, such as serum copper and lymphangiogram, have proven helpful in following the activity of the disease.¹¹ The major benefit to the patient has been the individualization of care permitted by exacting evaluation.

SUMMARY

1. Thirty-two patients were staged by operation for Hodgkin's disease at the University of Nebraska Medical Center over a five year period.

2. Important information about spleen involvement can be assessed accurately only by celiotomy.

3. Significant changes in evaluation and treatment results in 59% of those undergoing a staging operation.

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Pediatric Hernias: Indications for Surgery

PART II

HIATAL HERNIA

Hiatal hernia in infants and children has drawn increasing attention in recent years, more in Europe than the U.S. The frequency of the diagnosis appears to vary considerably from one center to another. This may be because chalasia, a frequently recognized entity in infants, may be the early form of hiatal hernia, and the distinction between the two is subject to considerable interpretation.²¹ It is certain that the disease is sought for more diligently by some clinicians than by others.

Hiatal hernia is said to occur in approximately 1:1000.^{3, 6, 8} Among children the onset of most cases is in infancy, especially the first month. It is usually of the sliding type but para-esophageal types have been reported.¹⁵ The presence of gastric folds above the level of the diaphragm can best be demonstrated by x-ray immediately after the passage of barium.¹⁹

Kehrer et al have performed manometric studies on normal infants, and have demonstrated intraluminal pressure characteristics quite similar to those of normal adults.¹³ The area corresponding to the lower esophageal sphincter demonstrates a 9-12 mm zone in which at the end of the expiratory phase, a pressure of 5-8 mm Hg above resting pressure in the gastric fundus is recorded. These pressure profiles were nearly un-

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altered in those patients with a minor form of hiatal hernia and gastroesophageal reflux, but in those patients with a major form of hiatus hernia (fixed epiphrenic pouch and peptic esophagitis) the pressure gradient between esophagus and stomach was non-existent. It was not clear whether the sphincteric failure was acquired secondary to peptic changes in the esophagus, or represented an inborn weakness of the lower esophageal sphincter.

The most prevalent sign of major hiatal hernia is malnutrition.²² Vomiting and bleeding are the most common symptoms. Other symptoms are dysphagia/feeding problems, pneumonia, recurrent upper respiratory infections, failure to thrive, and retrosternal pain. One 6 day old infant was reported to have nocturnal screaming fits, presumably from pain.²² The diagnosis of hiatal hernia should be considered by the alert clinician in any malnourished infant with vomiting. Another serious and dramatic complication is that of so called dying spells — acute

aspiration pneumonia associated with cardio-respiratory arrest.¹² The presence of recurrent aspiration pneumonia in an infant requires that the diagnosis of hiatal hernia be ruled out.

Many patients with hiatus hernia have other associated problems. In Jewett and Waterston's report, cerebral disorders and Down's syndrome were found in a surprising 25%.¹² Chrispin has suggested that opening and closing of the lower esophageal sphincter is linked to deglutition by a neural pathway.² In children with central nervous system disorders this reflex is said to be absent, resulting in the sphincter being continuously open with constant reflux into the esophagus.

Some sort of duodenal/pyloric obstructive disease has been found in 10-20% of cases,¹² and this must be looked for in the proper assessment of these patients.

The treatment of hiatal hernia in most cases is medical. Medical management consists of maintaining the patient in a semi-upright position, not less than 60°, around the clock for a period of 3 months.^{7, 19} This may then be followed by another 3 month period of semirecumbancy. A good response will be achieved in about 14 days in most of those patients who will ultimately be regarded as medical cures. Thickened feeds may be helpful, but antacids and anti-spasmodics are held to be unnecessary.

In several series, about 85% of patients will be cured by this regimen,^{12, 22} but careful long term follow-up is indicated. The clinician should be wary of the patient who vomits less frequently at age 6-9 months, for the patient may be forming a stricture rather than recovering from his disease.

The remaining patients will require surgical intervention. Failure of medical management is the indication for operation in 30% of those operated. In the remaining 70%, operation has been done for various complications and associated conditions. These include refractory esophagitis, esophageal stricture, recurrent aspiration pneumonia, cardio-respiratory arrest, and gastric volvulus. Gastropexy, as advocated by Boerema, has often been utilized as the surgical procedure, but it appears that the

operation of choice is a fundoplication of the Nissen type, sometimes with gastrostomy. As performed in infants and children, the operation is relatively simple and accompanied by little morbidity and mortality. In those patients with gastric retention, a pyloroplasty or other gastric outlet procedure should be done in addition.

DIAPHRAGMATIC HERNIA

Diaphragmatic hernias may be congenital or acquired. The latter are secondary to some sort of trauma or inflammatory process, and may occur at any time in life. The congenital diaphragmatic hernias are of greatest interest in the pediatric age group, however. They occur once in 2000 births.²⁷ Antero medial (retrosternal or parasternal) hernias protrude through the foramen of Morgagni. They constitute only about 3% of diaphragmatic hernias, and are very often asymptomatic, being found accidentally on chest x-ray.¹⁸

The Bochdalek hernia is by far the commonest congenital hernia of the diaphragm. It occurs posterolaterally, through the unobliterated pleuroperitoneal canal, and is left-sided in 85% of cases.

Patients with Bochdalek hernias fall into two distinct groups. In one, the patients are older children or even adults, with minimal or no symptoms of respiratory or gastrointestinal disorder. The largest group however, is that of the neonates who may have acute respiratory problems. These patients present some of the most dramatic and dangerous situations seen in pediatric surgery.

The infant usually develops cyanosis, dyspnea, and tachycardia, often immediately, but sometimes progressively over a period of hours as the herniated viscera fill with air, and as, with increasing respiratory effort, more viscera are sucked up into the chest.

The baby may appear to have a larger than normal chest, with a narrow waist and scaphoid abdomen. The mediastinum and apical cardiac impulse may be shifted, and the chest may be either tympanitic or dull to percussion. Bowel sounds in the chest are heard infrequently.

A chest x-ray will show shift of the mediastinum to the contralateral side, and usually multiple air filled loops of bowel in the chest with paucity of air in the abdomen. On occasion, in the newly born who has not yet swallowed much air, the chest film may mimic that of effusion. In the differential diagnosis, eventration of the diaphragm must be considered, but the distinction may not be of great practical importance.

Congenital diaphragmatic hernia may also be confused on x-ray with congenital lobar emphysema, congenital adenomatoid malformations of the lung, congenital lung cysts, and postpneumonic pneumatoceles. This distinction is an important one and may be aided by the presence of normal amounts of air in the abdomen.

The pathophysiology of the Bochdalek hernia is still not entirely clear. The presence of intestine in the hemithorax during fetal development causes a hypoplastic/dysplastic lung on the affected side. This lung has tortuous bronchi and deficient alveoli and is incapable of normal gas exchange, yet can cause intra pulmonary shunting.

Other factors which compound the problem of these unfortunate infants are mediastinal shift, and persistent fetal circulation with shunting right to left across the foramen ovale and the patent ductus arteriosus. With the foregoing, and the dependency of the newborn on diaphragmatic respirations the child develops increasing hypoxia and acidosis, resulting in further intrapulmonary shunting. Thus begins an ever accelerating spiral of cause and effect which ultimately results in the demise of up to 75% of these infants who develop symptoms within the first 48 hours of life, and which can only be interrupted by prompt surgical intervention.¹⁸

The diagnosis should be made as early as possible, confirmed by x-ray, and the child should immediately be intubated with a nasogastric tube to prevent accumulation of air in the herniated viscera. An endotracheal tube should be installed through which high concentrations of oxygen can be given. Care must be taken to not exceed a positive pressure of 15 to 20 cm H₂O, in order to avoid pneumothorax.⁴ Operative repair of

the defect should be undertaken as soon as possible, after minimal resuscitation measures.

Repair of the defect may be approached either through the abdomen or the chest. Because of greater ease, and because of the associated 30% rate of malrotation of the bowel, we prefer the abdominal approach. This also makes it possible to leave a ventral hernia in those cases where the abdominal cavity is too small to accept the intrathoracic viscera. The proper preoperative and postoperative management of these patients represents one of the most formidable challenges to confront the pediatric surgeon and neonatologist, even with the most sophisticated neonatal care facility.

SUMMARY

This has been a brief review of the hernias of infancy and childhood. Emphasis has been placed on the indications for surgery, and certain areas of controversy.

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Hemoperfusion: A New Treatment for Severe Drug Overdose

THE treatment of drug overdoses has undergone few changes in recent years. Maximum supportive care for the Grade IV comatose patient with parenteral fluids, vasopressors, and artificial respiration as needed has proven very effective. Drug specific therapy with diuresis, fluid challenge, and manipulation of urinary pH are also effective treatments augmenting drug elimination.

For 1 to 4% of patients, however, this care proves inadequate and the patient succumbs to the poison. Hemodialysis initially appeared to be the ideal therapy for this group, holding forth the promise of rapidly clearing the blood directly of toxins. For most drugs, especially barbiturates and glutethimides, hemodialysis proved ineffective because of strong protein binding preventing transport across the cellophane membrane, and the highly hydrophobic and lipophilic nature of the drugs. Initial attempts to overcome these barriers utilizing different dialysis baths, such as cooking oil proved to be not only messy, but of little therapeutic value.

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Activated charcoal is known to be a very effective absorbent and has been used orally as part of the standard early treatment of drug overdoses for many years.¹

Activated charcoal is prepared by burning high carbon content natural products such as coconut shells. After crushing and purifying, the charcoal is ready to use. It seemed only logical to use activated charcoal as a direct adsorbent to detoxify blood. This system was first tested in vitro in 1948.² A number of problems prevented the initial wide spread use of this system. The charcoal proved to be an extremely effective adsorbent that removed not only toxins, but also caused severe hypoglycemia and hypocal-

cemia. In addition, the charcoal activated the coagulation system and clotting prevented high blood flow rates and markedly hindered toxin adsorption. Severe thrombocytopenia also resulted because of blood incompatibility, leaving the subject in danger of bleeding.³ A final problem preventing use of the system was charcoal microemboli.⁴ Small fines of charcoal produced in the purification process could escape through any blood filter leading to a fairly large load of charcoal emboli during the detoxification process.

These problems were overcome by a number of different steps. Saline washing followed by air washing eliminated many of the charcoal fines. Blood compatibility was achieved by coating the charcoal with a thin layer of cuprophane or other biocompatible substance such as albumin or acrylic hydrogel. This also lessened the clotting tendency and thrombocytopenia.⁵ In vitro studies have shown that the coating, which is 0.05 microns thick, does not significantly interfere with toxin adsorption.⁶ Hypoglycemia is prevented by prerinsing the charcoal with dextrose just prior to its use, allowing glucose equilibration during hemoperfusion. Once these modifications were made the system was used in vivo in 1964,⁷ and commercially prepared systems became available in 1975.

The clearance of specific drugs using hemoperfusion both in vivo and vitro has been tested and is significantly better than that provided by hemodialysis (Table #1). In addition, most of the drugs commonly taken in overdose suicide attempts are readily removed by charcoal hemoperfusion (Table #2).

Another additional method of hemodetoxification that has proven extremely efficient is nonionic resin hemoperfusion.⁸ A resin consisting of a copolymer of polystyrene and divinyl benzene (Amberlite XAD-4) has shown to be at least as effective as charcoal in removing most drugs.⁹ However, blood compatibility is a problem, and as with charcoal, high dose heparin therapy is needed.

Currently, four systems are available for hemodetoxification. Three consist of activated charcoal and one is a resin. The charcoal systems are the **B-D Hemodetoxifier**, the

TABLE #1
Clinical Drug Clearance (ml/min)

	Hemodialysis	Hemoperfusion
Methypylon	80	230
Glutethimide	60	150
Methaqualone	29	230
Phenobarbital	10	228

TABLE #2
Drugs Adsorbed By Activated Charcoal/Amberlite

1. Acetaminophen	9. Meprobamate
2. Amitriptyline	10. Methotrexate
3. Barbiturates	11. Methaqualone
4. Carbon Tetrachloride	12. Meperidine
5. Chlordane	13. Phenols
6. Digoxin	14. Quinine
7. Ethylchlorvynol	15. Salicylates
8. Glutethimide	

Hemocol Hemoperfusion column, and the **Gambro Adsorba 300C**. In general, the last two systems are comparable — both consisting of 300 grams of activated and coated charcoal and packed loose in a polystyrene case. The **B-D** system is 94 grams of uncoated charcoal placed on a rolled strip of adhesive tape and placed in a casing. In this system two cartridges should be used together. There is little clinical difference between the three systems except for the potential for more thrombocytopenia in the **B-D** system. The **Extracorporeal** resin system is slightly different. The resin does not remove metabolites other than drugs and has been used up to 10 hours without system saturation. The charcoal system cartridges are used for approximately three hours before replacing the cartridge, if needed.

The set up for all these systems consists of standard hemodialysis blood access, such as two Shaldon cannulas inserted into a femoral vein. Single needle set up cannot be used. The cartridges are prepared by rinsing first with 500 ml of 5% dextrose in water followed by two liters of normal saline containing heparin. Manufacturers' instructions should be followed closely. The blood lines are connected to a monitoring system with a blood pump. I have been using our standard Drake-Willock hemodialysis machine. Specific modules for this use with monitoring systems and a blood pump are available. The patient's clotting times are kept at 2½ to 3 times normal with heparin infusion during the treatment to prevent thrombosis.

This system, although very efficient, is not only time consuming but also expensive. Since most drug overdoses will survive with conservative care, when should it be used? Some authorities recommend specific drug plasma levels before using.⁹ However, these are difficult to obtain rapidly, and 25 to 30% of all drug overdoses are multiple drug ingestions. In these cases, drug levels would not be as valuable. Specific clinical parameters are listed (Table #3).

In the past 9 months I have treated 6 patients with hemoperfusion for drug overdoses using the Gambro Adsorba 300C system. All patients have survived. Case specific drug ingestions can be seen (Table #4).

TABLE #3
Indications For Use of Hemoperfusion
In Drug Overdose

1. Severe Clinical Intoxication
 - A. Hypotension
 - B. Hypothermia
 - C. Hypoventilation
2. Progressive deterioration despite excellent supportive management.
3. Continued coma in the face of aspiration pneumonia or other respiratory problems.

TABLE #4
Drug Overdoses Treated With Hemoperfusion

1. Doriden
2. Elavil, Mellaril, Cogentin
3. Dilantin, Phenobarbital, Librium, Codeine, Salicylate
4. Phenobarbital, Dilantin
5. Unknown drugs (Stelazine?)
6. Doriden

TABLE #5
Changes In Drug Levels In Two Overdoses

	— Doriden —	
Pre-	4.1 mg. %	2.6 mg. %
1 hr.	4.3 mg. %	2.1 mg. %
2 hr.	1.6 mg. %	2.0 mg. %
3 hr.	2.4 mg. %	1.6 mg. %
	Toxic > 1 mg. %	

Drug levels were effectively lowered, as can be seen by the two cases involving glutethimide intoxication (Table #5). Three patients suffered hypotension during the treatment period. Two responded to saline

infusion, and the third to neosynephrine. Hemoperfusion was discontinued after two hours in one patient because of bleeding. This patient had only slight thrombocytopenia. On the average, the platelet count fell 29% and the calcium dropped 2.2 mg %. Neither change was symptomatic. In all patients the coma stage lessened from Grade IV to at least Grade II after hemoperfusion for three hours. Three became fully awake either during or immediately after perfusion. The other three were fully alert within 36 hours.

Hemoperfusion has proven very effective for the treatment of drug intoxication.¹⁰ Further applications of this concept, however, promise to revolutionize current therapies in other areas of medicine. Currently the system is being tested in the treatment of chronic uremia. Combined with ultrafiltration to remove fluids and urea, and oral resin to adsorb potassium and phosphorus, charcoal hemoperfusion has proven effective and may lessen total dialysis time by 33 to 50%.^{11, 12} When used in the dialysate system to remove toxins and regenerate the bath, an adsorbent system can make possible a portable, wearable dialysis system.

The system has also been used to treat patients with Grade IV hepatic coma secondary to acute hepatic failure.¹² Hemoperfusion can remove toxic products and decrease the coma stage dramatically, however, it cannot replace the synthetic functions of the liver and can only be used as a "tiding over" method until the acute process abates. Current statistics show an improved survival from 13% with conservative treatment to 24% with hemoperfusion.

In summary, hemoperfusion is an exciting, effective new tool for the physician treating drug overdoses, but it must be used with great restraint and when used, closely monitored. It has wide sweeping implications for the future in the treatment of uremia, and may prove beneficial in the therapy of acute hepatic failure. Its use should probably be restricted to referral centers having experience with hemodialysis, since the operating principles are very similar and requires trained ancillary personnel.

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Down Memory Lane

There were reported to the Omaha City Health Department in 1925, sixty-nine cases of acute anterior poliomyelitis, with a mortality of nineteen cases, or 27.5%.

Personally I feel that the operation of cholecystectomy was devised by a versatile surgeon, who diagnosed gallstones before operation. Not finding stones, he labelled the trouble, infected gallbladder and removed it. It was simple. He had an exhibit to show the patient's friends. Everybody was satisfied.

Vienna holds an enviable position among the post-graduate schools of the world, and, in diseases of the eye, ear, nose and throat it undoubtedly is today, as it was formerly, the greatest.

There are ministers who feel that free medical service is not only due them, but is not worth a word of thanks after rendered. Happily this class is not numerous. There are ministers of independence of character and of

business sense who see the justice of a doctor's fee and insist on paying.

The ideally safe exercise for old folks is to ride up in the elevator of a tall building and walk down, repeating the procedure *ad lib*.

A number of cases of Malta fever are reported to have occurred in Iowa.

A new Maternity hospital has been opened at Fremont.

Blood transfusions in a small hospital or isolated farm house differs in no way from a transfusion given in the most elaborately equipped metropolitan hospital.

A movement is on foot to establish a hospital at College View.

The medical profession must take an active interest in state and national politics if we ever hope to get the recognition to which we are entitled.

Nebraska State Medical Journal
April, 1928

President's Page

OUR HELPERS

A physician attains a level of competence after many years of education, examinations, and finally licensure. This culminates in the ability to cope with most all problems of the human body. Some physicians will take this basic educational background and build upon it to become specialists. But what happens after one becomes an M.D. or specialist? I'll tell you, every one wants to "help the doctor" but not in the sense the statement might imply. It's more like wanting to get into the act.

Out at the periphery of the medical profession is a whole "bevy" of helpers all helping the doctor to do the work of caring for the sick. Some will trim corns and calluses, some will exercise a stiff joint to aid the patients recovery, some will fit glasses and so on. Many are willing to act like a doctor until the doctor comes but a few carry the act too far. Some would expand their fields to include diagnosing and treating the ills of a patient, encroaching on the prerogative of the doctor. Don't get me wrong, most are willing to stay in their field of training and we as doctors are grateful for their assistance. But there seems always to be a few of "our helpers" that constantly push to expand their field, to do more than for which they were trained. In other words a few insist on playing doctor, being a little bit of a doctor and wanting to play whole doctor. They want to do a physician's work with lesser training and it's becoming quite a problem.

My answer to that problem is to let them do all the things they want to only after they take the prescribed academic courses. If they want to play the role of a doctor, let them apply to medical school, graduate, take the necessary examinations for licensure; then they wouldn't have to just act like doctors, they would be doctors free of the criticism of



trying to expand their role. They could then treat the bones in the foot or hand, prescribe eye medications or any other approved medicines used by physicians. They then could do the things they want without going to the legislature or seeking public sentiment. Let them qualify first then give them the expanded role, not expand the role and then qualify. Keep the horse before the cart.

My plea is, if you want to practice like a doctor, take the necessary training to do it right, don't expect a diploma mill or a couple of years of training in some branch of medical care to make you qualified. Go all the way, otherwise be content in your limited role, do an excellent job comensurate with your background. Don't let a little training make you think you know it all.

Arnold Lempka, M.D.



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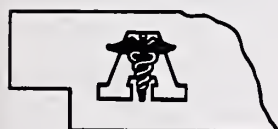
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Dr. and Mrs. James Brooke
Dr. and Mrs. William B. Mitchell
Dr. and Mrs. M. Allen Tompkins
Dr. Ruth E. Christensen



The Auxiliary

TALKING BOOKS

Talking Books is a program of the Library of Congress, Division of the Blind and Physically Handicapped, offering special reading services to the blind and physically handicapped across the country. In Nebraska the Regional Library at the Nebraska Library Commission in Lincoln and three subregional libraries at Hastings, Kimball and North Platte provide these services. In Omaha the Metropolitan Library Network, one of six networks in Nebraska, has Talking Books as an outreach service. The Omaha Public Library is its regional library and has its own librarian. The greater Omaha Metropolitan area has about six hundred patrons.

Application for service may be obtained from the region or subregional libraries. Anyone who is certified as unable to read conventional materials due to temporary or permanent visual or physical handicap is eligible to receive these special services. There is no charge for library services;

books and machines are loaned free and are sent to the patrons and returned postage free.

As a volunteer for Talking Books, I make home visits to set up service for new patrons who have been approved or to assist those already in the program. All calls are made by a previous appointment.

When I make the first call, I take with me a Talking Book machine or Cassette and catalogs. A demonstration is given on the operation of the record player or the cassette. In many cases the patron is asked to demonstrate back to make sure he understands how to operate the machine or has questions. Library procedures for ordering and returning materials are then explained. A request list of forty to fifty titles must be made out and returned to Lincoln to start the program. Assistance is given to those who cannot do it alone or have no one at home to help. Other details discussed are

where to call for service, and telephone numbers are provided; Talking Book Topics, a magazine and record mailed out every two months to all patrons; changing needles; magazines available on record or tape. In two weeks a callback is made to find out if service has been started and if the patron has any questions or problems.

On December 15, 1977, I received a letter

from Kathleen Jordan, Senior Administrator, Publications and Programs, American Medical Association Auxiliary, Inc., saying that Talking Books has been accepted by the Project Bank and will be listed in the edition, scheduled for completion in June of 1978.

Lulu M. Bach
Auxiliary to the Greater
Omaha Medical Society

Between Cases

Diagnosis Department.

Diagnosis: Superior humerus pain.

Quote Unquote.

For God's sake, no doctors! If a man's going to die, let him die.

From Sly Fox, by Larry Gelbart.

Words I Can Do Without.

That's something else; you're a doctor, so you know: albeit; gut reaction; the whole kit and caboodle.

The Interview.

History of drinking while intoxicated.

Definitions.

An expert: an ordinary man away from home giving advice.

Wilde.

I Agree.

One must regard the hyphen as a blemish to be avoided whenever possible.

Churchill.

Department Of Too Many Words.

He is an accountant by profession.

Department Of Statistics.

5,000 people die each year from liver disease, in England.

Department Of Gastroenterology.

It is estimated that 15 million Americans harbor gallstones.

Things We Once Thought.

It was once believed that God had provided a plant to cure every ailment.

Rocks In His Head?

He had a diagnosis of left cerebral calculus. This passed into the urethra where it lodged.

B.Z.

Heard On T.V.

I'm too sick to see a doctor.

On Aging.

How old would you be if you didn't know how old you are?

Anon.

Try The Appendix.

The last thing one discovers in writing a book is what to put first.

Pascal.

Section On Discrimination, Sex Division.

If it is a boy, please call me.

And if it is a girl?

Don't bother.

Roberta Silman: The grandparents.

—F.C.

COLACE prevents hard, dry stools common to constipation . . . and does it without laxative stimulation. COLACE assists peristalsis by simply letting intestinal water permeate stools.

COLACE helps to prevent painful straining at stool—particularly important in patients with delicate anorectal disorders. Safe and non-habit forming . . . COLACE, the simple water way to ease constipation from infancy to old age.

Simple drops of water
help make COLACE[®]
the most widely used
stool softener.

COLACE[®]
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MeadJohnson
PHARMACEUTICAL DIVISION

COMPATIBILITY



Eastern Tiger Swallowtail Butterfly
(*Papilio glaucus*)

Does it influence your choice of a peripheral/cerebral vasodilator*?

Vasodilan—compatible with coexisting diseases (e.g., glaucoma, diabetes)

Vasodilan has not been reported to affect the course of coexisting disease; it has not been reported to affect blood sugar levels or to raise intraocular pressure.

Vasodilan—compatible with concomitant therapy

Vasodilan has not been reported to affect the treatment of coexisting disease; it is compatible with such drugs as hypoglycemics and miotics.

Vasodilan—compatible with your total regimen for vascular insufficiency

Vasodilan can be a valuable adjunct in planning a total therapeutic program for vascular insufficiency.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has assified the indications as follows:

Possibly Effective:

For the relief of symptoms associated with cerebral vascular insufficiency.

In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.

Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral administration when administered in recommended doses. Should not be given immediately after parturition or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses.

For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836



VASODILAN[®] 20-mg tablets

(ISOXSUPRINE HCl)

20 mg q.i.d. recommended dosage

Mead Johnson
PHARMACEUTICAL DIVISION

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This asthmatic isn't worried about his next breath...

**he's active
he's effectively
maintained on**

QUIBRON[®]

Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

- high theophylline for effective around-the-clock therapy
- 100% free theophylline
- individualized theophylline dosage schedule

Indications: For the symptomatic treatment of bronchospastic conditions such as bronchial asthma, asthmatic bronchitis, chronic bronchitis, and pulmonary emphysema.

Dosage: Initial: Adults: 1-2 capsules or 1-2 tablespoonfuls elixir every 6-8 hours, children 8-12: 1 tablespoonful or one capsule every 6-8 hours and children under 8: 3 to 5 mg theophylline/kg body weight every 6-8 hours. Theophylline dosage may be cautiously increased to 2000 mg/24 hr in adults or 7 mg/kg in children; monitoring of serum theophylline levels at higher dosages is recommended.

Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea and vomiting. The frequency of adverse reactions is related to the serum theophylline level and are not usually a problem at serum theophylline levels below 20 µg/ml.

How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

Mead Johnson

PHARMACEUTICAL DIVISION

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In Memoriam

*By medicine life may be prolong'd
yet death*

Will seize the doctor too.

—Shakespeare

DR. OTTO M. TROESTER

Doctor Otto M. Troester died on September 29, 1977, at the age of eighty-seven. Doctor Troester was born near Hampton on October 27, 1889.

He graduated from Lincoln Medical College in 1918 and started his practice in Hampton in 1920.

Doctor Troester was recognized by the Nebraska Medical Association as a fifty-year practitioner in 1968.

He is survived by his widow, Elsie of Hampton; three sons, Dr. Otto S. Troester of Lincoln, James M. Troester of Prairie Village, Kansas and R. Michael Troester of Lincoln; a sister, Mrs. Emma Oppliger of Overland Park, Kansas; seven grandchildren, other relatives and many friends.

Books



Current medical diagnosis and treatment; by Marcus A. Krupp, M.D. and Milton J. Chatton, M.D.; 1098 pages; limp cover, \$17.00; published 1978 by Lange Medical Publications, Los Altos, California.

This book first appeared in 1962, and reappears in a new edition every year, so that this would be its seventeenth edition, which speaks well for its being up-to-date. I counted 32 authors, including the two author-editors.

There are 33 chapters, an appendix, and a good index. There are a few figures, tables, and unnumbered references. CMD&T appears in Spanish, Italian, Serbo-Croatian, Portuguese, German, and Japanese versions.

The printing makes for easy reading; the appendix has an excellent list of normal laboratory values. The book is recommended.

—F.C.

Coming Meetings

CRIPPLED CHILDREN'S CLINICS —

April 1 — Broken Bow, Elks Lodge

April 15 — Hartington, Trinity Lutheran Church

May 6 — Ainsworth, Elementary School

May 13 — Ogallala, Elks Lodge

NEBRASKA MEDICAL ASSOCIATION
ANNUAL SESSION — April 30 - May 3,
1978, Lincoln Hilton Hotel, Lincoln, Nebraska.

THE FIRST INTERNATIONAL SYMPOSIUM OF THE INTERNATIONAL COLLEGE OF PEDIATRICS — June 18-22, 1978, Finlandia Hall, Helsinki, Finland. Plenary Sessions, Symposia, Round-table discussions, Free papers. George D.

Maragos, M.D., M.Sc., Associate Professor of Pediatrics, Creighton University Medical School, Omaha, Nebraska, 68108, USA.

AMERICAN MEDICAL ASSOCIATION —
Annual Convention, June 17-22, 1978, St. Louis, Missouri.

NEBRASKA MEDICAL ASSOCIATION
FALL SESSION — September 21-23, 1978,
Lincoln Hilton Hotel, Lincoln, Nebraska.

AMERICAN MEDICAL ASSOCIATION —
Interim Session, House of Delegates,
December 2-6, 1978, Palmer House, Chicago, Illinois.

AMERICAN MEDICAL ASSOCIATION —
Winter Scientific Program, December 7-10,
1978, Las Vegas, Nevada.

Welcome New Members

Mary Gatewood Batchelder, M.D.
10730 Pacific Street, #234
Omaha, Nebraska 68114

David J. Harter, M.D.
Department of Radiation Oncology
Bishop Clarkson Memorial Hospital
Omaha, Nebraska 68105

John J. Heieck, M.D.
8300 Dodge, #331
Omaha, Nebraska 68114

Walter W. Huurman, M.D.
University of Nebraska Medical Center
42nd and Dewey Avenue
Omaha, Nebraska 68105

Philip G. Itkin, M.D.
3925 Dewey Avenue
Omaha, Nebraska 68105

David L. Kiple, M.D.
924 Sharp Building
Lincoln, Nebraska 68508

Hieu Le Nguyen, M.D.
Shelton
Nebraska 68876

Tra Thanh Nguyen, M.D.
109 North 15th Street
Norfolk, Nebraska 68701

Van Tuong Nguyen, M.D.
505 North 5th Street, Apt. 6
Beatrice, Nebraska 68310

V. A. Raiker, M.D.
Stromsburg
Nebraska 68666

REINSTATED MEMBERS

Charles L. Barton, M.D.
630 North Cotner
Lincoln, Nebraska 68505

Bradley M. Berman, M.D.
University of Nebraska Medical Center
42nd and Dewey Avenue
Omaha, Nebraska 68105

Elliott R. Chappell, M.D.
104 West 31st Street
Kearney, Nebraska 68847

Medicine

The American flag, flourished against the tower of the state capitol, flies in full color each month on the cover of the *Nebraska Medical Journal*. This journal is led by a physician-editor, Dr. Frank Cole, whose extraordinary writing gives great flavor to its pages. His editorials and other pieces are short, witty, conversational. They spring from long experience and a rare humanity, and speak to a fascination of myriad topics. Dr. Cole is nationally admired, and rightly so. The Nebraska journal won first prize in its category (journals with under 3,000 circulation) in the Sandoz contest.

VIRGINIA MEDICAL
November, 1977

Notice.

We will be happy to deliver the Nebraska Medical Journal to your home. To help us do this, please send your home address to the Nebraska Medical Association, 1902 First National Bank Building, Lincoln, Nebraska 68508.

You will have the Journal where you want it, so you can read it when you are through at the office and hospital, when you are home and television is not at its best.

And the members of the Auxiliary will get to see it, too.

—F.C.

WashingtonNotes

Hospitals.

The fate of the plan for federal controls on hospital revenue may be decided shortly in a crucial Congressional arena — the House Ways and Means Subcommittee on Health.

The subcommittee has before it the Administration's plan for a flat nine percent ceiling on hospital revenue increases and the proposal by subcommittee Chairman Dan Rostenkowski (D-Ill.) for a standby federal control plan if the voluntary effort fails. Many members of the Subcommittee are opposed to both approaches and the final vote may be close.

(The voluntary effort — VE — is a broad national program led by the American Hospital Association, the American Medical Association, and the Federation of American Hospitals that seeks to achieve significant reductions in the rate of increase in hospital costs over the next several years. It has a national steering committee and state-level committees in all but one or two states.)

Rostenkowski in a speech before the American Hospital Association's Annual Meeting has set forth his plan as a possible compromise that might secure the backing of health providers. He said the controls would take effect only if the voluntary effort to curb costs failed to reach its goal of a two percent drop in the annual rate of hospital revenue increases.

However, the AHA said the Rostenkowski plan "would have an adverse impact on the efforts already underway in the voluntary effort for hospital cost containment." "Furthermore," the Association said, "arbitrary caps on hospital revenues are tantamount to wage-price controls on one segment of an industry and, as such, are inequitable and administratively unworkable."

The AHA contended in its alert that Rostenkowski's triggering mechanism for the revenue cap "could place the legislative controls in effect despite a successful voluntary effort. For example, the voluntary effort will be deemed to have failed even if the rate

of increase in costs is reduced by 4 percent or more in the next two years, but the decrease is the sum of a greater than 2 percent reduction, the first year and a less than 2 percent reduction the second.

The triggering mechanism, according to the AHA, "would destroy the incentive to reduce costs voluntarily. If hospitals in the aggregate reduced their costs as much as possible in one year, they could find it more difficult to cut as much the next. On the other hand, if hospitals limit their efforts in the first year, they probably would be in a better position to sustain their level of effort the following year. In other words, the provisions of the triggering mechanism would hamper efforts to reduce costs as rapidly as possible."

In addition, the triggering mechanism does not take into account changes in inflation or gross national product increases from year to year, according to the AHA. "The voluntary effort provides that its goal be adjusted in accordance with the changes in the rate of increase (inflation plus real growth) in the GNP," said AHA.

Health planning law.

Congress is moving early on the controversial Health Planning Law which comes up for renewal this year. Sen. Edward Kennedy (D-Mass.) and Rep. Paul Rogers (D-Fla.) have introduced legislation to amend the law and the Administration has set forth its ideas on changes.

The three approaches are similar, generally strengthening the present law rather than diluting it. The three proposed bills all would subject expensive new equipment in physician's offices to planning approval, the most significant change from the standpoint of physicians.

Appearing before the House Commerce Subcommittee on Health, officials of the American Medical Association urged a flat repeal of the Planning Law. If this can't be accomplished, AMA amendments shifting

authority and responsibility for planning to the local level should be adopted, the witnesses said.

Testifying for the AMA were Frank Jirka, Jr., M.D., of Berwyn, Ill., and Vice Chairman of the AMA Board of Trustees; and Archie Johnson, M.D., of Raleigh, N.C.

Dr. Jirka told the Subcommittee that "health planning must be flexible enough to accommodate the different medical needs of various communities and of individual patients and thus to insure the availability of high quality medical care for all persons."

"This is achievable best by placing the planning authority and power at the local level and by insuring that those most directly involved in and have the basic responsibility for making decisions regarding the quality, distribution, and availability of services."

Rather than improve the planning program, most of the amendments submitted so far would impose additional limitations and ration health resources, Dr. Jirka said.

Three major proposals in the planning amendment legislation introduced by Subcommittee Chairman Rogers "cause us deep concern" Dr. Jirka said. These would extend the certificate of need to physicians' offices, require states to develop a program to discontinue health services deemed to be inappropriate, and give the Health, Education and Welfare Department much tighter control over Title 16 (Health Resources Development) funds.

Broadening certificate of need to cover purchase of major medical equipment in physicians' offices would be a dramatic extension of the Planning Law that could have long range unintended effects, the AMA official said.

State societies visit Congress.

Representatives from 17 state medical societies recently visited their Congressmen in Washington to give their views on important pending health bills in a one-day legislative blitz.

55 physicians, medical society executives and other officials took part in the visitation sponsored by the AMA.

The state delegations focussed their talks on the hospital cost containment and health planning measures now heading for crucial votes. The state officials reported Congressmen were eager to hear their views and welcomed the interchange.

States represented included California, Colorado, Connecticut, Florida, Illinois, Indiana, Louisiana, Maryland, Michigan, New Jersey, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, Virginia, and West Virginia.

HMO.

The government has issued new rules requiring health maintenance organizations (HMOs) to make their services available and accessible around the clock, to operate on a fiscally sound basis, and to create governing bodies with more consumer representation.

In addition, the regulations cut the paperwork for Medicare and Medicaid patients who enroll in HMOs.

One change would reimburse HMOs that serve Medicare patients for the cost of insurance the HMOs buy against catastrophic illness among their members.

Laetrile.

To see if laetrile has any documentable antitumor effects, the National Cancer Institute will collect medical records from cancer patients who have used the controversial drug.

Laetrile is now available in 14 states, the NCI officials hope data from the large number of patients thought to be using the drug will be decisive in deciding whether or not to proceed to clinical trials. Laetrile has failed to show a reproducible antitumor effect in at least a dozen animal trials.

According to NCI's Neil Ellison, M.D., the same criteria used in judging case reports of other cancer therapies will be used to judge laetrile. Cancer diagnosis in patients submitting records will have to be proven by biopsy, and objective evidence of anti-tumor effects will have to be shown by x-ray, scanning, physical examination, or other means.

NCI is interested in patients who used laetrile with or without the metabolic therapy and chelating agents now being advocated by laetrile proponents.



"Towards A Theology of Medical Science" Father Clifford Stevens

Father Clifford Stevens is a priest of the Archdiocese of Omaha and pastor of Saint Francis Church, Neligh, Nebraska. He is a graduate of Bays Tawn, attended Creighton University and completed his studies for the priesthood at Conception Seminary, Conception, Mo. Ordained in 1956, he served pastoral assignments in the Archdiocese of Omaha and in 1961 entered the Air Force Chaplaincy. During his years in the Air Force, he pioneered programs of adult theology and began extensive research and writing on the relationship between theology and science and technology. In addition to his assignment in the Air Force, Father Stevens has also served as the editor of theological publications and served briefly as the founder-director of the Theological Research Institute in Santa Fe. Father Stevens is the author of several books and his articles have been published by numerous periodicals.

Annual Recognition and Religion Banquet Sunday, April 30 - 7:00 p.m.

110th Annual Session

Registration Forms for the Session and Ticket Forms will be distributed in early April

Physicians' Classified

Advertisements in this column are run at a rate of twenty cents per word with a minimum of \$10.00 per insertion. Copy must be received by the fifth of the month preceding date of publication and should not exceed 50 words. Each advertisement will be taken out following its first appearance unless otherwise instructed. Where numbers follow advertisements, replies should be addressed in care of The Nebraska Medical Journal, 1902 First National Bank Building, Lincoln, Nebraska 68508.

STAFF PHYSICIAN — General practitioner to perform general examination, care, and treatment of patients or staff at state psychiatric hospital. Surgery limited to emergency first-aid care. Forty-hour week with rotating on-call duty. Salary negotiable in range of \$29,892 to \$40,272. Excellent benefits. Contact: H. D. Herrick, M.D., Superintendent, Norfolk Regional Center, Box 1209, Norfolk, Nebraska 68701. Call Collect: 402-371-4343.

PSYCHIATRIC RESIDENCY: Vacancies for (PG2 through PG4 only) positions for July 1, 1978, for those who have a regular Iowa license or can obtain one by reciprocity or via FLEX. Prepare for career in private practice, community clinics or hospital-based psychiatry. Emphasis on close supervision of intensive individual and group psychotherapy, OPD, Children's Unit, Adolescent Unit. Neurology affiliation with University of Iowa. The stipends are: 1st year, \$22,360; 2nd year, \$23,478; 3rd year, \$24,674. Intensity and diversity of training program appreciated best by personal visit. T. B. McManus, M.D., Superintendent, Mental Health Institute, Cherokee, Iowa 51012. Equal Opportunity Employer. Call Collect 712-225-2594.

4-78



**110th
ANNUAL
SESSION**



**April 30 -
May 3, 1978**



LINCOLN HILTON



110TH ANNUAL SESSION NEBRASKA MEDICAL ASSOCIATION

OF SPECIAL INTEREST

PURPOSE:

To advance the science and art of medicine and to elevate the standards of medical education. Meetings of the Annual Session are devoted to the scientific work of the members, disseminating to members and others, facts and opinions relating to medical knowledge, treatment and procedures.

The overall goal of this scientific program is to substantiate or change the attitude and approach of the physician to the solution of a given medical problem, present new knowledge in a specific area, update data and introduce new specific skills and techniques.

OBJECTIVES:

1. To recognize patient treatment, techniques and advances regarding the hypothermic patient.
2. To recognize the value of biofeedback in patient treatment.
3. To provide physicians with accurate, applicable information on circadian rhythms.
4. To provide some new concepts in the treatment and diagnosis of several disease entities.
5. To provide an opportunity for physicians to select areas of interest for study and to interact with fellow colleagues.

SPONSORSHIP:

The meeting is sponsored by the Scientific Sessions Committee of the Nebraska Medical Association.

CREDIT:

This program is acceptable for 8½ prescribed hours by the American Academy of Family Physicians.

As an organization accredited for continuing medical education, the Scientific Sessions Committee of the NMA certifies that this continuing medical education offering meets the criteria for 8½ hours of credit in Category I of the Physician's Recognition Award of the American Medical Association, provided it is used and completed as designed.

ANNUAL RECOGNITION AND RELIGION BANQUET — Sunday, April 30, 7:00 p.m., Grand Ballroom, Lincoln Hilton. Recognition of Fifty-Year Practitioners. The Reverend Father Clifford Stevens, St. Francis Church, Neligh, NE, will present a talk entitled "Towards A Theology Of Medical Science." Edward A. Holyoke, Jr., M.D., Chairman.

SCIENTIFIC BREAKFAST MEETING — Tuesday, May 2, 7:30 a.m., South Platte Room, Lincoln Hilton, LCDR Michael F. Boyer, MC, USN, Antarctic Support Forces, will present a scientific lecture entitled "The Hypothermic Victim: No Longer Cold and Dead." Y. Scott Moore, M.D., Chairman.

ATHLETIC MEDICINE LUNCHEON — Tuesday, May 2, 12:15 p.m., Fanny's, Lincoln Hilton. Noted author, George Plimpton, New York, New York, is the guest speaker. His presentation is entitled "An Amateur Among The Pros." Patrick E. Clare, M.D., Chairman.

PRESIDENT'S RECEPTION — Honoring the President of the Nebraska Medical Association and the President of the Nebraska Medical Association Auxiliary. Tuesday, May 2, 6:00 p.m., East Hills Supper Club at 70th and Sumner Streets, Lincoln.

FUN NIGHT — An evening of exceptional entertainment and superb cuisine for your enjoyment. Dinner at 7:00 p.m. Political satirist, Mark Russell, will entertain. The President's Reception will immediately precede the dinner. Tuesday, May 2, East Hills Supper Club at 70th and Sumner Streets, Lincoln. Y. Scott Moore, M.D., Chairman.

PAST PRESIDENT'S BREAKFAST — Wednesday, May 3, 7:00 a.m., Parlour C, Lincoln Hilton.

ANNUAL DISTINGUISHED LUNCHEON — Installation of Houtz G. Steenburg, M.D., as the new NMA President. NBC News Correspondent, Irving R. Levine, will discuss "The Carter Administration — After 16 Months." Wednesday, May 3, 12:00 noon, Grand Ballroom, Lincoln Hilton.

SCIENTIFIC SESSIONS COMMITTEE

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Y. Scott Moore, M.D., Convention Chairman	Lincoln
Richard A. Cottingham, M.D.	McCook
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ACKNOWLEDGEMENTS

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Nebraska Department of Health, Lincoln, Nebraska

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Nebraska

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Omaha, Nebraska

United States Army Medical Department, Fort Leaven-
worth, Kansas

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President 1977-1978



HOUTZ G. STEENBURG, M.D.
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President

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II. Louis J. Gogela, M.D., Lincoln	1978
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V. Warren R. Miller, M.D., Columbus	1979
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Alternate Delegates to AMA

John D. Coe, M.D., Omaha 1978
Louis J. Gogela, M.D., Lincoln 1979

Delegate to North Central Medical Conference

Russell L. Gorthey, M.D., Lincoln 1978

Editor, Nebraska Medical Journal

Frank Cole, M.D. Lincoln

NMA Staff

Kenneth E. Neff, Executive Secretary Lincoln
William L. Schellpeper, Assistant
Executive Secretary Lincoln

ANCILLARY MEETINGS

NEBRASKA CHAPTER, AMERICAN COLLEGE OF
SURGEONS ANNUAL BUSINESS MEETING —
Sunday, April 30, 4:30 p.m., North Platte Room,
Lincoln Hilton.

UNIVERSITY OF NEBRASKA PRECEPTOR BREAK-
FAST — Tuesday, May 2, 7:30 a.m., Parlours A
and B, Lincoln Hilton.

UNIVERSITY OF NEBRASKA COLLEGE OF
MEDICINE ALUMNI MEETING AND SOCIAL
HOUR — Tuesday, May 2, 4:15 p.m., Parlours A,
B and C, Lincoln Hilton.

NOTES

BUSINESS SESSIONS TIMETABLE

Board of Councilors

Sunday, April 30, 1978, 11:00 a.m., North Platte Room

Board of Directors

Tuesday, May 2, 1978, 7:00 a.m., Parlour C

House of Delegates

First Session: Sunday, April 30, 1978, 1:00 p.m.,
Grand Ballroom

Second Session: Monday, May 1, 1978, 8:00 a.m.,
Grand Ballroom

Third Session: Wednesday, May 3, 1978, 7:30 a.m.,
Grand Ballroom

Nominating Committee

First Session: Monday, May 1, 1978, 10:30 a.m.,
Room 203

Second Session: Tuesday, May 2, 1978, 11:15 a.m.,
Room 203

Third Session: Tuesday, May 2, 1978, 4:15 p.m.,
Room 203

PROGRAM

Nebraska Medical Association 110th Annual Session

SUNDAY EVENING, APRIL 30, 1978

7:00 ANNUAL RECOGNITION AND RELIGION
BANQUET — Grand Ballroom
Sponsored by the NMA Medicine and Religion
Committee

For Members and Wives

Presiding —

Edward A. Holyoke, Jr., M.D., Ogallala
Chairman, NMA Medicine and Religion
Committee

Recognition of Fifty-Year Practitioners

Leland C. Albertson, M.D.
Omaha

Joseph Kuncel, M.D.
Alliance

Olin J. Cameron, M.D.
Omaha

Isaiah Lukens, M.D.
Tekamah

John M. Christlieb, M.D.
Bellevue

Clarence S. Moran, M.D.
Omaha

Roy S. Cram, M.D.
Burwell

Bert W. Pyle, M.D.
Gothenburg

Ben N. Greenberg, M.D.
York

John R. Schenken, M.D.
Omaha

Guest Speaker

"Towards A Theology Of Medical Science"
The Reverend Father Clifford Stevens
Saint Francis Church
Neligh, Nebraska

Father Clifford Stevens is a priest of the Archdiocese of Omaha and pastor of Saint Francis Church, Neligh, Nebraska. He is a graduate of Boys Town, Nebraska, attended Creighton University and completed his studies for the priesthood at Conception Seminary, Conception, Missouri. Ordained in 1956, he served pastoral assignments in the Archdiocese of Omaha and in 1961 entered the Air Force Chaplaincy, serving on bases in California, Alaska, New Mexico and Japan. Upon leaving the Air Force in 1968, he became executive editor of THE PRIEST magazine and then editor-publisher of SCHEMA XIII, a journal for the priest in the modern world. From 1973-76, he was Assistant Director of Liturgy in Santa Fe, a liturgical institute in New Mexico, and served a brief tenure as founder-director of the Theological Research Institute in Santa Fe. He is at present at work on a definitive study of the thought and work of Saint Thomas Aquinas which will be published in 1980.



Father Clifford Stevens
Neligh, Nebraska

PROGRAM

MONDAY, MAY 1, 1978

Morning

8:00 Registration, Lobby

SPORTSMAN'S DAY

10:00 Skeet and Trap Shoot
Lincoln Gun Club
4855 North 48th Street
(Participation by Preregistration Only)
(Range also available at 1:00)
Guy M. Matson, M.D., Chairman

11:30 Sportsman's Day Luncheon
The Country Club of Lincoln
3200 South 24th Street
(Participation by Preregistration Only)
James H. Rickman, M.D., Chairman

Afternoon

1:00 Golf Tournament
The Country Club of Lincoln
3200 South 24th Street
(Shotgun Tee Off)
(Participation by Preregistration Only)
James H. Rickman, M.D., Chairman

1:00 Skeet and Trap Shoot
Lincoln Gun Club
4855 North 48th Street
(Participation by Preregistration Only)
Guy M. Matson, M.D., Chairman

2:00 Tennis
Lincoln Racquet Club Ltd.
5300 Old Cheney Road
(Participation by Preregistration Only)
William T. Griffin, M.D., Chairman

Evening

5:30 Sportsman's Day Social Hour
The Country Club of Lincoln
3200 South 24th Street
James H. Rickman, M.D., Chairman

6:30 Sportsman's Annual Award Dinner
The Country Club of Lincoln
3200 South 24th Street
(Participation by Preregistration Only)
James H. Rickman, M.D., Chairman

PROGRAM

TUESDAY MORNING, MAY 2, 1978



LCDR Michael F. Boyer,
MC, USN

Doctor Michael F. Boyer graduated from the University of Nebraska College of Medicine in 1975. He was born near Barneston, NE, and attended the U.S. Naval Academy at Annapolis, Maryland, graduating in 1969. He did postgraduate work at the U.C. Berkeley and obtained a Master of Science Degree in Engineering, after which he completed Marine Corps training and was designated a Naval Aviator. The past year he was the Senior Medical Officer for OPERATION DEEP FREEZE and the National Science Foundation's Antarctic Research Program.



John V. Basmajian, M.D.
Hamilton, Ontario, Canada

Doctor John V. Basmajian graduated from the University of Toronto Faculty of Medicine in 1945. He was head of the Anatomy Department at Queen's University Faculty of Medicine in Canada until 1969, when he moved to Emory University School of Medicine in Atlanta, Georgia, and became the Director of the Regional Rehabilitation Research and Training Center and Professor of Rehabilitation Medicine, Anatomy and Psychiatry. He became the Director of Rehabilitation Programmes for Chedoke Hospitals and Professor of Medicine at McMaster University School of Medicine in the summer of 1977. The author of ten books published in five languages, and 250 articles, Doctor Basmajian is also the editor of a 20 volume Rehabilitation Library Series. In recognition "of distinguished service to the disabled," the American Congress of Rehabilitation Medicine presented to him its 1977 Gold Key Award.

PROGRAM

TUESDAY MORNING, MAY 2, 1978

7:30 to 9:00 **SCIENTIFIC BREAKFAST MEETING — South Platte Room**

Moderator —
Y. Scott Moore, M.D., Lincoln
Family Practice

"The Hypothermic Victim — No Longer Cold and Dead"
LCDR Michael F. Boyer, MC, USN
Antarctic Support Forces

Questions and Discussion

8:00 Registration, Lobby

8:00 Exhibits Open, Grand Ballroom
Coffee available in Exhibit Area

9:00 to 12:00 **SYMPOSIUM ON BIOFEEDBACK — Grand Ballroom**

Moderator —
Jerry A. Reed, M.D., Lincoln
Internal Medicine

"Your Patient Had A Stroke, Now What?"

9:00 "Early Problems"

10:00 Break

10:15 "Late Problems and Biofeedback"

11:15 "Open-Feedback Session"

— John V. Basmajian, M.D.
Director, Rehabilitation Centre
Chedoke Hospitals
Hamilton, Ontario, Canada

— Donald Marx, R.P.T.
Director of Physical Therapy
Lincoln General Hospital
Lincoln

Questions and Discussion

SUNDAY, APRIL 30, 1978

- 11:00 Board of Councilors,
North Platte Room
- 1:00 House of Delegates,
Grand Ballroom
- 7:00 Annual Recognition and
Religion Banquet,
Grand Ballroom

MONDAY, MAY 1, 1978

Morning

- 8:00 House of Delegates,
Grand Ballroom
- 8:00 Registration,
Lobby
- 10:00 Skeet and Trap Shoot,
Lincoln Gun Club
4855 North 48th Street
- 10:30 Nominating Committee,
Room 203
- 11:30 Sportsman's Day Luncheon,
The Country Club of Lincoln
3200 South 24th Street

Afternoon

- 1:00 Golf Tournament,
The Country Club of Lincoln
3200 South 24th Street
- 1:00 Skeet and Trap Shoot,
Lincoln Gun Club
4855 North 48th Street
- 2:00 Tennis,
Lincoln Racquet Club Ltd.
5300 Old Cheney Road

Evening

- 5:30 Sportsman's Social Hour,
The Country Club of Lincoln
3200 South 24th Street
- 6:30 Sportsman's Annual Award Dinner,
The Country Club of Lincoln
3200 South 24th Street

TUESDAY, MAY 2, 1978

Morning

- 7:00 Board of Directors,
Parlour C
- 7:30-9:00 Scientific Breakfast Meeting,
South Platte Room
- 8:00 Registration,
Lobby
- 8:00 Exhibits Open,
Grand Ballroom
- 9:00-12:00 Symposium on Biofeedback,
Grand Ballroom
- 11:15 Nominating Committee,
Room 203
- 12:15 Athletic Medicine Luncheon,
Fanny's

Afternoon

- 1:30 Visit the Exhibits,
Grand Ballroom
- 2:00 Presentation of AMA-ERF Checks and
Scholarship Program Checks,
Grand Ballroom
- 2:05-4:20 Symposium on Circadian Rhythms,
Grand Ballroom
- 4:15 Nominating Committee,
Room 203
- 4:15 Visit the Exhibits,
Grand Ballroom

Evening

- 6:00 President's Reception for Members and
Wives,
East Hills Supper Club
70th and Sumner Streets, Lincoln
- 7:00 Fun Night,
East Hills Supper Club
70th and Sumner Streets, Lincoln

WEDNESDAY, MAY 3, 1978

Morning

- 7:00 Past President's Breakfast,
Parlour C
- 7:30 House of Delegates,
Grand Ballroom
- 8:00 Registration,
Lobby
- 8:00 Visit the Exhibits,
Grand Ballroom
- 9:00-12:00 Symposium on What's New In Medicine,
North Platte Room, South Platte Room
& Fanny's
- 11:45 Visit the Exhibits,
Grand Ballroom

12:00 Annual Distinguished Luncheon,
Grand Ballroom

- Installation of New President
Guest Speaker —
Irving R. Levine

PROGRAM

TUESDAY NOON, MAY 2, 1978

12:15 **ATHLETIC MEDICINE LUNCHEON — Fanny's**
Sponsored by the NMA Subcommittee on
Athletic Injuries

Presiding —
Patrick E. Clare, M.D., Lincoln
Chairman, NMA Subcommittee on Athletic
Injuries

Guest Speaker
"An Amateur Among The Pros"
George Plimpton
New York, New York

Mr. George Plimpton is a graduate of Harvard and Cambridge, a member of the jet set and a professional amateur. He has played tennis with Pancho Gonzales, golf with Sam Snead and bridge with Oswald Jacoby. He fought three rounds with Archie Moore, who gave him a bloody nose; pitched an endless inning to a line-up of major-league All Stars; was last-string quarterback for the Detroit Lions during the training season; swam against Don Schollander and did such a bang-up job on the bells, playing with the New York Philharmonic under Bernstein, that they asked him to repeat his performance for the recording. His experiences are reported in his entertaining books: PAPER LION, OUT OF MY LEAGUE and THE BOGEY MAN. His ambition is to know everyone of his time who is famous, interesting or talented — and to be whatever they are.



Mr. George Plimpton
New York, New York

1:30 Visit the Exhibits, Grand Ballroom

PROGRAM

TUESDAY AFTERNOON, MAY 2, 1978

2:00 Presentation of AMA-ERF Checks
Presentation of NMF Student Research Scholarship Program Checks, Grand Ballroom

2:05 **SYMPOSIUM ON CIRCADIAN RHYTHMS —**
to **Grand Ballroom**
4:20 For Members and Wives

Moderator —
Richard A. Cottingham, M.D., McCook
Radiology

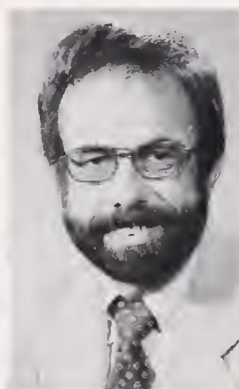
"Circadian Rhythms In Medicine"
— Charles M. Winget, Ph.D.
Research Scientist
Biomedical Research Division, NASA,
Ames Research Center, Moffett Field, Calif.

— John R. Beljan, M.D.
Dean, School of Medicine
Vice Provost, Wright State University
Dayton, Ohio

Questions and Discussion

Charles M. Winget, Ph.D.
Moffett Field, California

Charles M. Winget, Ph.D. is research scientist with NASA Ames Research Center, Moffett Field, California. Doctor Winget is a 1957 graduate of the University of California at Berkeley. He received his Ph.D. degree in Comparative Physiology. He spent four years at the University of Toronto as Associate Professor of Comparative Physiology where he taught in the School of Veterinary Medicine and the College of Agriculture. After leaving Canada, Doctor Winget joined NASA Ames Research Center, Moffett Field, California. There, he has held the positions of project scientist for project Bio-Satellite as well as project manager for human research studies and since 1972, has been senior research scientist for Biomedical Research Division at Ames Research Center.



John R. Beljan, M.D.
Dayton, Ohio

Doctor John R. Beljan graduated from the University of Michigan Medical School in 1954. Following a surgical residency at University Hospital in Ann Arbor, he spent ten years in the U.S. Air Force Medical Corps serving in a variety of command positions in Europe and the United States. During the mid-1960's, he was a member of the Ground Launch Support Team for Project Gemini, and he still remains active in aerospace medicine. In 1966, he became the second faculty member of the new medical school at the University of California at Davis and later served as Associate Dean for Medical Education at Davis. Doctor John R. Beljan arrived in Dayton in early 1974 as the founding Dean of the Wright State University School of Medicine.



4:15 Visit the Exhibits, Grand Ballroom

PROGRAM

TUESDAY EVENING, MAY 2, 1978

6:00 PRESIDENT'S RECEPTION
For Members and Wives
East Hills Supper Club
70th and Sumner Streets, Lincoln

7:00 FUN NIGHT
East Hills Supper Club
70th and Sumner Streets, Lincoln

Y. Scott Moore, M.D., Chairman



An evening of fun and entertainment at Lincoln's beautiful East Hills Supper Club. A delightful dinner followed by political satirist, Mark Russell.



Mr. Mark Russell
Washington, D.C.

Mr. Mark Russell has been the resident political comedian of the Shoreham Hotel in Washington, D.C., since 1961. He has presented a series of one-man specials on the Public Television Network, produces a syndicated column for over 100 newspapers and has produced three record albums entitled "Up the Potomac Without a Canoe," "The Face On the Senate Floor" and "Wild, Weird, Wired World of Watergate." He has appeared on The Tonight Show, Merv Griffin Show, Today Show, Steve Allen Show, two David Frost Specials and various other programs. Mark Russell has been called many things during his comparatively long-running comedy career at the Shoreham Hotel, including "Washington's one-man laugh-in," "the capital's court jester," "the resident wit of the Shoreham Hotel" and "Washington's favorite cabaret satirist."

PROGRAM

WEDNESDAY MORNING, MAY 3, 1978

8:00 Registration, Lobby

8:00 Visit the Exhibits, Grand Ballroom
Coffee available in Exhibit Area

9:00 SYMPOSIUM ON WHAT'S NEW IN
to MEDICINE — North Platte Room, South
12:00 Platte Room and Fanny's

General Moderator —
Y. Scott Moore, M.D., Lincoln
Family Practice

Three Simultaneous Round-Table Discussions
Scheduled In Fifty-Minute Segments
10 Minutes Between Each Segment

Informality and Free Discussion Will Prevail

I. "The Spectrum and Management of Hepatitis B"
"Update on Cimetidine-H₂ Antagonist"

—Rowen K. Zetterman, M.D., Omaha
Gastroenterology/Internal Medicine

II. "Complimentary Uses of Newer Images,
Nuclear, CT and Ultrasound"

—Lawrence R. James, M.D., Omaha
Radiology

III. Athletic Medicine
"Knee Arthroscopy, Rehabilitation and Cy-Bex
Demonstration"

—Patrick E. Clare, M.D., Lincoln
Orthopedic Surgery

—Charles W. Newman, M.D., Lincoln
Orthopedic Surgery

—Jerry Weber, RPT and Assistant Trainer
University of Nebraska
Department of Athletics



11:45 Visit the Exhibits, Grand Ballroom

PROGRAM

WEDNESDAY NOON, MAY 3, 1978

12:00 ANNUAL DISTINGUISHED LUNCHEON —
Grand Ballroom

For Members and Wives

Presiding —

James H. Rickman, M.D., President
Lancaster County Medical Society

Installation of Houtz G. Steenburg, M.D.

Guest Speaker

"The Carter Administration — After 16 Months"

Irving R. Levine
NBC News Correspondent
Washington, D.C.

Mr. Irving R. Levine graduated from Brown University and received a Master's Degree from the Columbia Graduate School of Journalism. In the 24 years that he has been an NBC News correspondent, he has reported and interpreted events on television and radio on four continents. At present, he is Economic Affairs correspondent in Washington, D.C. Prior to his current assignment, he was based as NBC News correspondent for 10 years in Rome, four years in Moscow, two years in Tokyo and a year in London. Mr. Levine is the author of "MAIN STREET, U.S.S.R.," which was on the national non-fiction best-seller lists and is used as a university textbook; "MAIN STREET, ITALY;" "TRAVEL GUIDE TO RUSSIA," described by LIFE Magazine as the one essential book for travelers to the Soviet Union and "THE NEW WORKER IN SOVIET RUSSIA." News events have taken him all over the world, and his commentaries and reports have been regular features of "NBC Nightly News," "Today" and other NBC News programs.



Mr. Irving R. Levine
Washington, D.C.

Past Presidents Nebraska Medical Association

Gilbert C. Monell, M.D., Omaha	1868-69
James H. Peabody, M.D., Omaha	1869-70
N. B. Larsh, M.D., Nebraska City	1870-71
R. R. Livingston, M.D., Plattsmouth	1871-72
A. Bowen, M.D., Nebraska City	1872-73
H. P. Mathewson, M.D., Omaha	1873-74
John Black, M.D., Plattsmouth	1874-75
L. H. Robbins, M.D., Lincoln	1875-76
J. P. Peck, M.D., Omaha	1876-77
L. J. Abbott, M.D., Fremont	1877-78
E. M. Whitten, M.D., Nebraska City	1878-79
Harvey Link, M.D., Millard	1879-80
S. D. Mercer, M.D., Omaha	1880-81
M. W. Stone, M.D., South Omaha	1881-82
A. H. Sowers, M.D., Lincoln	1882-83
Victor H. Coffman, M.D., Omaha	1883-84
F. G. Fuller, M.D., Grand Island	1844-85
W. W. Knapp, M.D., Lincoln	1885-86
Richard C. Moore, M.D., Omaha	1886-87
George H. Peebles, M.D., Lincoln	1887-88
Milton Lane, M.D., Kearney	1888-89
J. C. Denise, M.D., Omaha	1889-90
D. A. Walden, M.D., Beatrice	1890-91
Charles Inches, M.D., Scribner	1891-92
M. L. Hildreth, M.D., Lyons	1892-93
A. S. von Mansfelde, M.D., Ashland	1893-94
H. B. Lowry, M.D., Lincoln	1894-95
J. E. Summers, M.D., Omaha	1895-96
F. D. Haldeman, M.D., Ord	1896-97
Wilson O. Bridges, M.D., Omaha	1897-98
A. R. Mitchell, M.D., Lincoln	1898-99
Robert McConaughy, M.D., York	1899-00
H. M. McClanahan, M.D., Omaha	1900-01
Wm. B. Eby, M.D., Ainsworth	1901-02
A. B. Anderson, M.D., Pawnee City	1902-03
B. F. Crummer, M.D., Omaha	1903-04
R. C. McDonald, M.D., Fremont	1904-05
A. F. Jonas, M.D., Omaha	1905-06
F. A. Long, M.D., Madison	1906-07
Harold Gifford, M.D., Omaha	1907-08
L. M. Shaw, M.D., Osceola	1908-09
P. H. Salter, M.D., Norfolk	1909-10
J. P. Lord, M.D., Omaha	1910-11
A. D. Nesbit, M.D., Tekamah	1911-12
I. N. Pickett, M.D., Odell	1912-13
D. C. Bryant, M.D., Omaha	1913-14
J. P. Gilligan, M.D., O'Neill	1914-15
E. W. Rowe, M.D., Lincoln	1915-16
W. F. Milroy, M.D., Omaha	1916-17 (to 12-31-17)
C. L. Mullins, M.D., Broken Bow	1918
J. M. Bannister, M.D., Omaha	1919
H. W. Orr, M.D., Lincoln	1920
M. S. Moore, M.D., Gothenburg	1921
B. B. Davis, M.D., Omaha	1922

Past Presidents Nebraska Medical Association

B. F. Bailey, M.D., Lincoln	1923
Morris Nielsen, M.D., Blair	1924
Palmer Findley, M.D., Omaha	1925
H. J. Lehnhoff, M.D., Lincoln	1926
H. E. Potter, M.D., Fairbury	1927
B. R. McGrath, M.D., Grand Island	1928-29 (to 5-14-29)
F. S. Owen, M.D., Omaha	1929-30
K. S. J. Hohlen, M.D., Lincoln	1930-31
Lucien Stark, M.D., Norfolk	1931-32
A. E. Cook, M.D., Randolph	1932-33
Adolph Sachs, M.D., Omaha	1933-34
Joseph Bixby, M.D., Geneva	1934-35
Claude A. Selby, M.D., North Platte	1935-36
George W. Covey, M.D., Lincoln	1936-37
R. W. Fouts, M.D., Omaha	1937-38
Homer Davis, M.D., Genoa	1938-39
A. L. Miller, M.D., Kimball	1939-40
Clayton F. Andrews, M.D., Lincoln	1940-41
W. P. Wherry, M.D., Omaha	1941-42
Dexter D. King, M.D., York	1942-43
A. L. Cooper, M.D., Scottsbluff	1943-44
Floyd L. Rogers, M.D., Lincoln	1944-45
Charles McMartin, M.D., Omaha	1945-46
Earle G. Johnson, M.D., Grand Island	1946-47
G. E. Charlton, M.D., Norfolk	1947-48
J. E. M. Thomson, M.D., Lincoln	1948-49
J. D. McCarthy, M.D., Omaha	1949-50
C. H. Sheets, M.D., Cozad	1950-51
D. B. Steenburg, M.D., Aurora	1951-52
Harold S. Morgan, M.D., Lincoln	1952-53
James F. Kelly, M.D., Omaha	1953-54
Earl F. Leininger, M.D., McCook	1954-55
Wm. E. Wright, M.D., Creighton	1955-56
J. M. Woodward, M.D., Lincoln	1956-57
R. Russell Best, M.D., Omaha	1957-58
Fay Smith, M.D., Imperial	1958-59
E. E. Koebbe, M.D., Columbus	1959-60
Fritz Teal, M.D., Lincoln	1960-61
A. J. Offerman, M.D., Omaha	1961-62
O. A. Kostal, M.D., Hastings	1962-63
R. F. Sievers, M.D., Blair	1963-64
R. E. Garlinghouse, M.D., Lincoln	1964-65
Willis D. Wright, M.D., Omaha	1965-66
Dan A. Nye, M.D., Kearney	1966-67
Robert J. Morgan, M.D., Alliance	1967-68
Frank H. Tanner, M.D., Lincoln	1968-69
J. Whitney Kelley, M.D., Omaha	1969-70
Clarence R. Brott, M.D., Beatrice	1970-71
Roger D. Mason, M.D., McCook	1971-72
Frank P. Stone, M.D., Lincoln	1972-73
John D. Coe, M.D., Omaha	1973-74
James H. Dunlap, M.D., Norfolk	1974-75
Warren G. Bosley, M.D., Grand Island	1975-76
Harlan L. Papenfuss, M.D., Lincoln	1976-77

Auxiliary



MRS. GUY M. MATSON
Lincoln, Nebraska
President, 1977-1978



MRS. HARRY D. SHAFFER
Lincoln, Nebraska
President, 1978-1979



MRS. MANUEL A. BERGNES
Norristown, Pennsylvania
President-elect
American Medical
Association Auxiliary, Inc.

Auxiliary

53rd Annual Meeting of the Nebraska Medical Association Auxiliary

EACH PHYSICIAN'S SPOUSE IS ENCOURAGED
TO REGISTER AND ATTEND THE ENTIRE
AUXILIARY PROGRAM. PLEASE JOIN US!

Registration: Lobby, Lincoln Hilton

Monday, May 1 — 8:30 a.m. to 3:00 p.m.

Tuesday, May 2 — 8:30 a.m. to 3:00 p.m.

Hospitality Room and Displays: Room 202

Convention Committees:

General Co-Chairmen:

Mrs. Stephen W. Carveth
Mrs. Joseph G. Rogers

Registration:

Mrs. Robert T. Byington

Publicity:

Mrs. Robert E. Collins

Courtesy and Social:

Mrs. Howard A. Dinsdale

Transportation:

Mrs. Richard C. Olney

Finance and Reservations:

Mrs. Glen F. Lau

County Exhibits:

Mrs. Clifford M. Hadley, Lyons

Hospitality:

Mrs. H. A. Hansen

Style Show:

Mrs. John D. Baldwin

Hostesses:

Lancaster County Medical Auxiliary

Auxiliary

PROGRAM

SUNDAY, APRIL 30, 1978

Evening

7:00 Annual Recognition and Religion Banquet,
Grand Ballroom, Lincoln Hilton
(Joint Meeting of Auxiliary and NMA)

Recognition of Fifty-Year Practitioners

Speaker —

"Towards A Theology Of Medical Science"
The Reverend Father Clifford Stevens
St. Francis Church
Neligh, Nebraska

MONDAY, MAY 1, 1978

Morning

8:30- Registration, Lobby, Lincoln Hilton
3:00

9:00- Coffee and Rolls, North Platte Room, Lincoln
9:30 Hilton

9:30 Annual Business Meeting, North Platte Room,
Lincoln Hilton.

All Members Urged To Attend

Mrs. Guy M. Matson, NMA Auxiliary President,
Presiding

Reports of Officers, Chairmen and County
Presidents
Business and Election of Officers
Memorial Service

Afternoon

12:30 No-Host Lunch and Exchange of Ideas with
Mrs. Manuel A. Bergnes
AMA Auxiliary President-elect
North Platte Room, Lincoln Hilton

Evening

5:00 Meet in Lincoln Hilton Lobby, if transportation
is needed for the evening events.
(Dress - Casual)

5:30 Home Tour and Social Hour
Home of: Mrs. M. J. Epp
6211 Cornell Road

6:45 Home Tour and Buffet Supper Benefitting the
Health Galleries
Home of: Mrs. Stephen W. Carveth
6300 Old Cheney Road

Auxiliary PROGRAM

TUESDAY, MAY 2, 1978

Morning

- 8:30- Registration, Lobby, Lincoln Hilton
3:00
- 10:30 Brunch, North Platte Room, Lincoln Hilton
Guest:
Mrs. Manuel A. Bergnes
President-elect AMA Auxiliary
Norristown, Pennsylvania
Presentation of Special Awards
Installation of Officers
Informal Modeling by Hovland-Swanson

Afternoon

- 2:00 Presentation of AMA-ERF Checks and
NMF Student Research Scholarship Program
Checks
Grand Ballroom, Lincoln Hilton
- 2:05- Symposium on Circadian Rhythms, Grand Ball-
4:20 room, Lincoln Hilton
(Joint Meeting of Auxiliary and NMA)
"Circadian Rhythms In Medicine"
—Charles M. Winget, Ph.D.
Research Scientist
Biomedical Research Division, NASA,
Ames Research Center, Moffett Field,
California
—John R. Beljan, M.D.
Dean, School of Medicine
Vice Provost, Wright State University
Dayton, Ohio

Evening

- 6:00 President's Reception for Members and Wives
East Hills Supper Club
70th and Sumner Streets, Lincoln
- 7:00 Fun Night
East Hills Supper Club
70th and Sumner Streets, Lincoln
An evening of fun and entertainment at
Lincoln's beautiful East Hills Supper Club. A
delightful dinner followed by political satirist,
Mark Russell.

Auxiliary PROGRAM

WEDNESDAY, MAY 3, 1978

Morning

- 9:00 Coffee, Parlours A and B, Lincoln Hilton
- 9:30 Post-Convention Board Meeting, Parlours A and
B, Lincoln Hilton
All Members Welcome
Mrs. Harry D. Shaffer, Presiding

Afternoon

- 12:00 Annual Distinguished Luncheon, Grand Ball-
room, Lincoln Hilton
(Joint Meeting of Auxiliary and NMA)
Installation of Houtz G. Steenburg, M.D.
Guest Speaker:
"The Carter Administration — After 16 Months"
Irving R. Levine
NBC News Correspondent
Washington, D.C.

Technical Exhibitors

110th Annual Session

BLUE CROSS AND BLUE SHIELD OF NEBRASKA, Omaha, Nebraska — Physicians are encouraged to stop by our booth. Plan representatives will be available to discuss Blue Cross and Blue Shield policies and procedures on subjects such as the Usual, Customary and Reasonable fee concept, our utilization review program and other subjects which may be of interest to physicians such as our company's adoption of the AMA's CPT 3 for Blue Shield claims.

DAIRY COUNCIL OF CENTRAL STATES, INC., Omaha, Nebraska — Display on nutrition education materials. Booklets, posters and leaflets covering topics such as weight control, prenatal nutrition and infant nutrition.

DORSEY LABORATORIES, Lincoln, Nebraska — Dorsey will have available medical, educational material on several new products. Patient aids which are helpful to you in your practice will also be available, and we would welcome your visit and will try to be of service to you.

MALLINCKRODT, INC., Hazelwood, Missouri — You are cordially invited to visit the Mallinckrodt booth where our representatives will be happy to provide any information you require concerning our unique and complete line of products. The products featured will be AQUATENSEN®, LUFYLLIN®-400, LUFYLLIN®-GG, RYNATAN®, RYNATUSS®, RYNA-C®, and RYNA-CXTM

NEBRASKA COMMUNITY MENTAL RETARDATION SERVICES — Representatives from the Mental Retardation Regional Offices will be available to answer questions concerning community services for mentally retarded individuals. Pamphlets, brochures and newsletters will be disseminated for a more complete and in-depth outline of the community-based programs accessible to the retarded individual and his or her family. The Association for Retarded Citizens will be represented stressing the roles between the community-based programs and parents of the retarded individual. A map depicting the specific mental retardation regions detailing vocational, educational and residential supports will be the focal point of the exhibit.

NEBRASKA DEPARTMENT OF HEALTH, Lincoln, Nebraska — Community Health Services. A visual display, coordinated with literature and audiovisuals, to provide basic introduction to the Community Health Services Program of the Nebraska State Department of Health. Emphasis on primary service areas of Health Education, Community Health Nursing and Environmental Health Services. Staff personnel will be available to answer questions.

ROCHE LABORATORIES, Nutley, New Jersey — Visit our representatives at Booth #16.

ST. PAUL FIRE AND MARINE INSURANCE COMPANY, St. Paul, Minnesota — The theme of the St. Paul exhibit will be "Medical Malpractice Loss Prevention." Highlighting this exhibit will be a display of the types of claims being experienced by Nebraska doctors. This information comes from a report called the "Claims Analysis System," a concept developed by the St. Paul in 1973. It outlines the number of claims by allegation and identifies the types of claims incurred with each Nebraska county.

SANDOZ PHARMACEUTICALS, East Hanover, New Jersey — Sandoz Pharmaceuticals invites you to stop by our exhibit where our representatives will be pleased to provide information on our products or on educational materials that we have available.

SOCIAL SECURITY DISABILITY, Lincoln, Nebraska — The Social Security Disability Insurance display consists of a well-lighted pictorial representation of the functions performed by this agency. This includes the adjudication of Adult and Childhood disabilities.

E. R. SQUIBB & SONS, Princeton, New Jersey — E. R. Squibb & Sons, Inc., has long been a leader in the development of new therapeutic agents and equipment for the prevention and treatment of disease. You are cordially invited to meet our pharmaceutical representatives who will be available at our exhibit to discuss our full line of products.

UNITED STATES AIR FORCE MEDICAL RECRUITING OFFICE, Omaha, Nebraska — The United States Air Force Health Professions Recruiting will be represented by Capt. Philip J. Rowen from their regional office in Omaha, NE.

UNITED STATES ARMY MEDICAL DEPARTMENT, Fort Leavenworth, Kansas — The US Army Medical Department counselor representative will provide information concerning its graduate medical education programs, medical treatment facilities, and opportunities to practice medicine as a Medical Corps officer.

UNITED STATES NAVY RECRUITING AREA 6, Omaha, Nebraska — Doctor Michael Boyer, LCDR, MC, USN and UNMC graduate will be available to share his naval experiences. The local Medical Programs Manager and Area Medical Programs Director will also be available.

Twenty-Hour Combination Chemotherapy in Advanced Breast Cancer — J. H. Goldie and L. A. Price (Royal Marsden Hosp, London, England) *Br Med J* 2:1064 (Oct 22) 1977.

Twenty-eight of 42 patients responded to combination chemotherapy with cyclophosphamide, 5-FU, methotrexate, and vincristine given over 20 hours. This kinetically-based approach has the following advantages for the patient: (a) marked reduction in bone marrow toxicity; (b) much less time in hospital; (c) a better quality of life; (d) no loss of therapeutic effect. This safer approach to cancer chemotherapy should be more widely adopted.

A Trial of Ascorbic Acid in the Treatment of the Common Cold — D. A. J. Tyrrell et al (Northwick Park Hosp, Harrow, Middlesex, England) *Br J Prev Soc Med* 31:189-191 (Sept) 1977.

A randomized controlled trial investigated the effect of 10 g of ascorbic acid taken during the first two and one-half days on the symptoms of the common cold. Of 1,524 volunteers recruited from various working groups in different parts of the country, colds developed in 482. There was no evidence that upper respiratory or general constitutional symptoms were alleviated by ascorbic acid. Among the men who had any colds at all, significantly fewer on active than on placebo treatment had two or more colds; however, this effect was not seen in women. Ascorbic acid is of no value in the treatment of the common cold.

Cytologic Evaluation of Breast Fluid in the Detection of Breast Disease — O. W. Sartorius et al (Peralta Cancer Research Institute, Univ of California, Oakland, CA 94609) *J Natl Cancer Inst* 59:1073-1078 (Oct) 1977.

The availability and cell content of aspirated breast fluid from 1,706 women were evaluated to determine the usefulness of breast fluid cytology as an indicator of breast disease. A newly developed aspirator was used to obtain cells from approximately 50% of the women tested. Fluids were most readily available from women between the

ages of 30 and 50 years. Although abnormal cytologies were observed in all age groups, the relative proportion of abnormal specimens as well as the degree of abnormality increased with age. More women over 40 years of age with high risk of breast cancer had cells classified in the more abnormal categories than did women in the normal risk group. To localize otherwise occult lesions, contrast ductography was performed on all women with very abnormal ductal cells. Women with atypical hyperplastic cytologies most commonly had benign and premalignant breast disease at subsequent biopsy. Of 27 women with fluids classified as suspected carcinomas 18 (66%) had small carcinomas. The presence of atypical cells in aspirated breast fluids has important clinical application for early detection of breast cancer.

Vasodilator Therapy in Acute Myocardial Infarction: Use of Sublingual Isosorbide Dinitrate — R. H. Baxter et al (Victoria Infirmary, Glasgow, Scotland) *Br Heart J* 39:1067-1070 (Oct) 1977.

The hemodynamic effects of a long-acting vasodilator, isosorbide dinitrate, was studied in ten patients after acute myocardial infarct associated with left ventricular failure. Wedge and pulmonary artery pressures were measured by Swan Ganz flow-directed catheter, and cardiac output by thermodilution technique. All patients had an elevated left ventricular filling pressure and this was significantly reduced from 20 ± 6 to 13.5 ± 5 mm Hg ($P < .001$) within ten minutes of sublingual isosorbide dinitrate and accompanied by a similar reduction in pulmonary artery pressure from 30 ± 7 to 20 ± 4 mm Hg ($P < .001$). The improvement was maintained for one to two hours. Mean systemic blood pressure fell significantly, cardiac output remained unchanged, and mean heart rate rose by five beats per minute. Patients with elevated end diastolic pressure and reduced cardiac index have a high mortality and 50% fail to show a hemodynamic response with frusemide. Vasodilators improve left ventricular performance but glyceryl trinitrate is limited by short action. Isosorbide dinitrate may have a place in the treatment of acute myocardial infarction.

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Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended at initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (Federal Register, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of susceptible to trimethoprim-sulfamethoxazole indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombocytopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, prothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, colitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasps. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasps. (5 ml)	½ tablet
40	18	2 teasps. (10 ml)	1 tablet
60	27	3 teasps. (15 ml)	1½ tablets
80	36	4 teasps. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

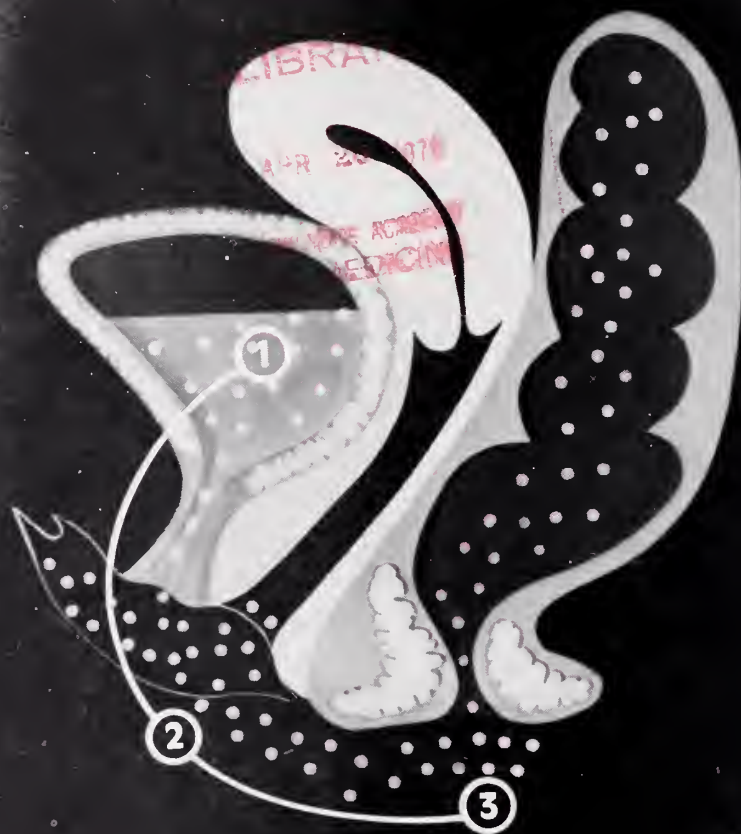


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The Nebraska Medical Journal

May, 1978



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Precautions: For External Use Only. Not for ophthalmic use. Keep away from eyes and mucosae. Very fair individuals should begin with a single application at bedtime allowing overnight medication. May bleach colored fabrics. Keep this and all other medications out of the reach of children.

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The Nebraska Medical Journal

EDITOR-FRANK COLE, M.D., No. 13, Bishop Square
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MAY 1978

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"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

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As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

X-ray Negative Dyspepsia — R. H. Salter
(Cumberland Infirmary, Carlisle, England)
Br Med J 2:235 (July 23) 1977.

One hundred forty consecutive patients referred for endoscopy with x-ray negative dyspepsia were studied, the barium meal having been performed using a double contrast method. No significant endoscopic abnormality was apparent in 133 patients. Of the seven patients in whom an abnormality was detected at endoscopy, three had chronic peptic ulcer and in four the lesion was mucosal (esophagitis or antral erosions). If a double contrast barium meal performed by an experienced radiologist has not shown any abnormality, an alternative explanation for the patient's dyspeptic symptoms should be sought unless there are other clinical pointers to upper gastrointestinal tract disease. Thus, endoscopy would assume third rather than second place in the sequence of investigations.

Relaxation Therapy in the Treatment of Hypertension — R. G. Jacob et al (Dept of Psychiatry and Behavioral Sciences, Stanford Univ Medical Center, Stanford, CA 94305) Arch Gen Psychiatry 34:1417-1427 (Dec) 1977.

The literature on the use of relaxation or relaxation-like procedures (relaxation therapy) in the treatment of hypertension was critically reviewed. Relaxation therapy resulted in greater reduction of blood pressure than placebo or other control procedures. A positive relationship was found between the average blood pressure decrease and the average pretreatment pressure. Relaxation-like therapies shared the features of muscular relaxation, regular practice, mental focusing, and task awareness. Research on the relative contributions of these components indicated that task awareness adds to the treatment effect in the laboratory setting, and that regular practice is necessary for optimal results in the clinical setting. The role of muscular relaxation and mental focusing is unclear. Relaxation therapy can become a useful adjunct to medication in the clinical management of hypertension, especially for individuals whose blood pressures remain high despite pharmacological treatment.

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Illustrations should be numbered and their locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be black (India ink) on pure white. Photographs should be on glossy paper and a minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

Manuscripts (original, not a carbon) should be sent directly to the Editor at the Journal's address.

Letters to the Editor submitted for publication should be prepared as above, and must carry the notation: To be Published.

Manuscripts not accepted for publication will not be returned to the author.

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Comparison of Vitamin D and 25-Hydroxy-vitamin-D in Therapy of Primary Biliary Cirrhosis — J. B. Wagonfeld et al (Dept of Medicine, Section of Gastroenterology, Univ of Chicago, Pritzker School of Medicine, Chicago, IL 60637) *Lancet* 2:391-393 (Aug 21) 1976.

Skeletal demineralization and low serum concentrations of 25-hydroxy-vitamin D were observed in patients with primary biliary cirrhosis. Neither oral nor parenteral vitamin D increased 25-hydroxy-vitamin D in serum or prevented further skeletal demineralization. In contrast, oral 25-hydroxy-vitamin D increased serum 25-hydroxy-vitamin D concentrations in all patients, and bone mineral content either improved or stabilized in all but one. 25-Hydroxy-vitamin D may be the preferred form of vitamin D therapy in primary biliary cirrhosis.

Thread Sutures Seen on Gastroscopy: Do They Cause Ulcers or Indigestion? — A. M. Hoare (Queen Elizabeth Hosp, Birmingham, England) and J. Alexander-Williams, *Br Med J* 2:996 (Oct 15) 1977.

Unabsorbable sutures in chronic ulcers were seen endoscopically in eight of 250 patients with symptoms after surgery for peptic ulcer. Mean peak acid output after pentagastrin was 19.7 mmol/hour, which was not significantly lower than 25.5 mmol/hour found in matched patients with ulcers without sutures but was significantly higher than 3.1 mmol/hour found in those with sutures alone. Therefore suture ulcers are related to high acid output and not the suture alone. Removal of sutures which were not associated with ulceration resulted in only temporary relief of symptoms. In a prospective study of vagotomy and antrectomy, silk sutures were used for the seromuscular layers in all patients. Endoscopy was performed six to 12 months after the operation, and sutures were seen in 55% of 11 patients with dyspepsia and 65% of 21 asymptomatic patients. Sutures alone do not cause dyspepsia.

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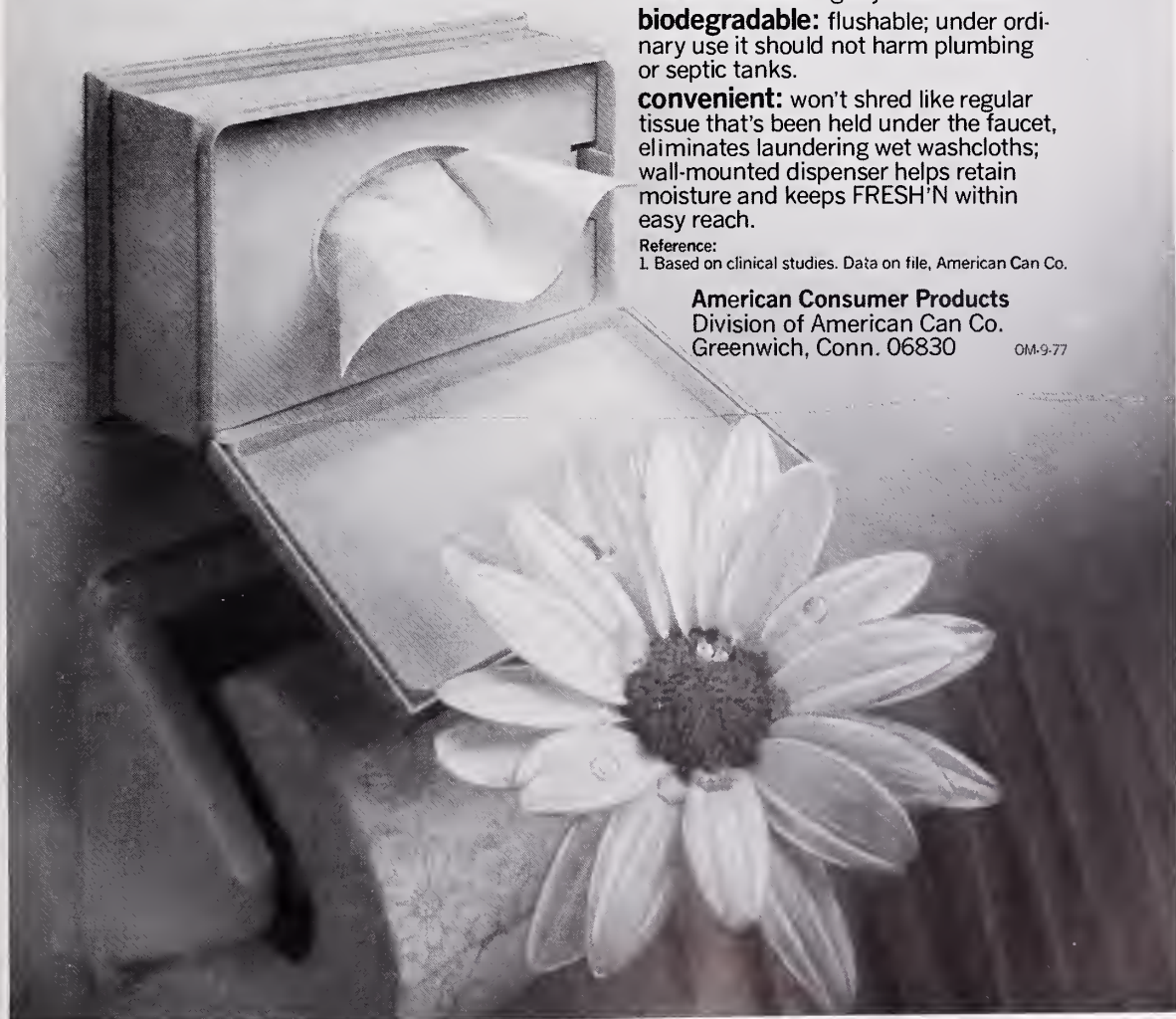
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DESCRIPTION Each tablet of PERCOCET®-5 contains 5mg oxycodone hydrochloride (WARNING: May be habit forming), 325mg acetaminophen (APAP).

INDICATIONS For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS Hypersensitivity to oxycodone or acetaminophen.

WARNINGS Drug Dependence Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of PERCOCET®-5, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, PERCOCET®-5 is subject to the Federal Controlled Substances Act.

Usage in ambulatory patients Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using PERCOCET®-5 should be cautioned accordingly.

Interaction with other central nervous system depressants Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with PERCOCET®-5 may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Usage in pregnancy Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, PERCOCET®-5 should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Usage in children PERCOCET®-5 should not be administered to children.

PRECAUTIONS Head injury and increased intracranial pressure The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions The administration of PERCOCET®-5 or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special risk patients PERCOCET®-5 should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

ADVERSE REACTIONS The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include euphoria, dysphoria, constipation, skin rash and pruritus.

DOSAGE AND ADMINISTRATION Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. PERCOCET®-5 is given orally. The usual adult dose is one tablet every 6 hours as needed for pain.

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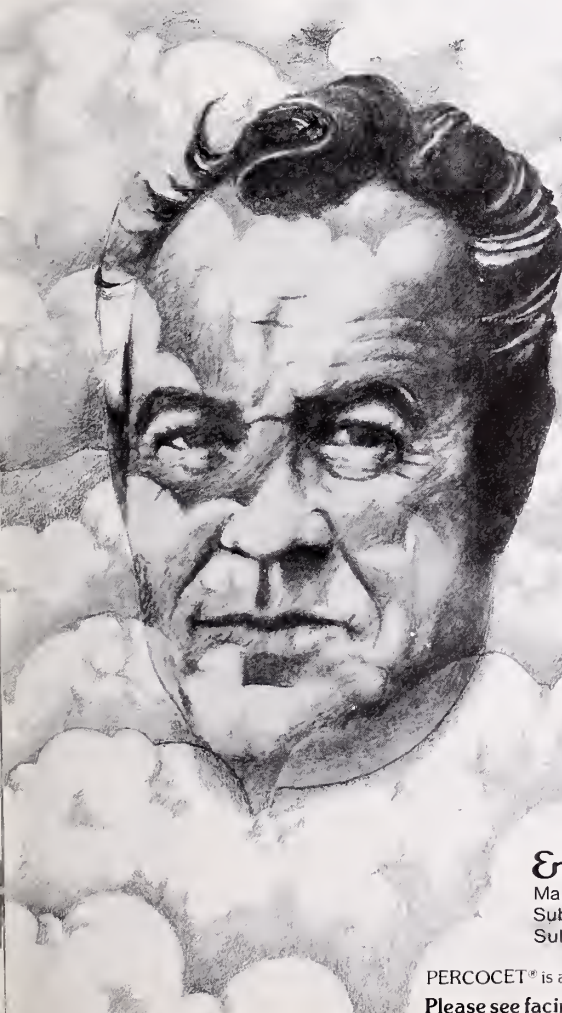
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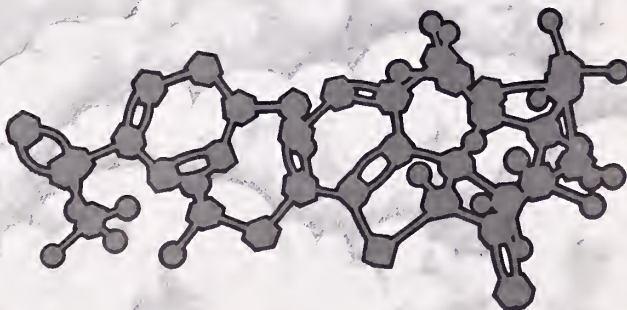


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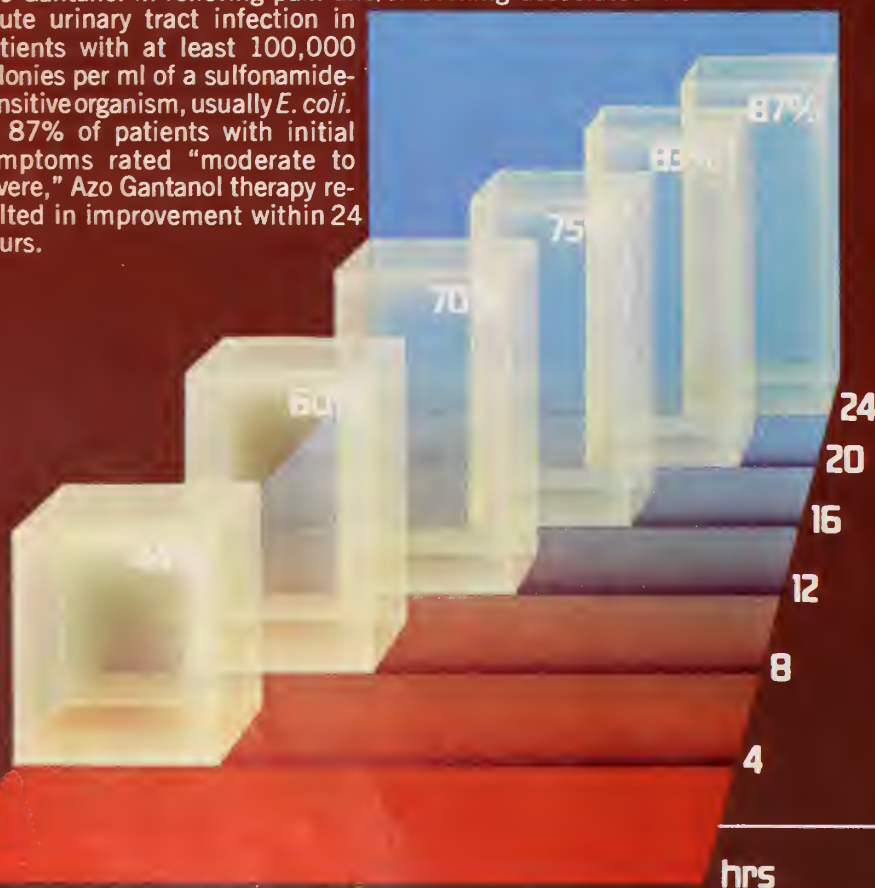
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Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergic bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

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Acute Renal Failure Following Halothane Anesthesia — J. R. Cotton, Jr, et al (Rush-Presbyterian-St Luke's Medical Center, Chicago, IL 60612) Arch Pathol Lab Med 100:628-629 (Dec) 1976.

Acute renal failure was observed post-operatively in a patient after halothane anesthesia. The clinical and pathologic findings in this case were remarkably similar to those found in patients with renal failure after methoxyflurane anesthesia.

Computed Tomography of Acoustic Neuroma — K. R. Davis et al (Massachusetts General Hosp, Boston, MA 02115) Radiology 124:81-86 (July) 1977.

Review of computed tomographic (CT) scans of 49 consecutive patients with surgical excised acoustic neuromas revealed positive scans in 80% following contrast enhancement, with 20% false negative scans. All tumors over 2 cm in diameter were shown by optimal scans with contrast enhancement. The positive scans were evaluated to determine the accuracy of the size of the lesions as predicted by the scan. A radiological approach to the evaluation of suspected acoustic neuromas is suggested.

Long-Term Administration of Corticosteroids in Myasthenia Gravis — J. D. Mann et al (Dept of Neurology, Box 147, Univ of Virginia Medical Center, Charlottesville, VA 22901) Neurology 26:729-740 (Aug) 1976.

Favorable results were obtained in 30 patients with myasthenia gravis, treated initially with high daily doses of prednisone, then subsequently maintained on lower doses for a protracted period. In 45 incidents of treatment, complete remission occurred in 69%, marked improvement in 20%, and moderate improvement in 7%. Nineteen patients proceeded to thymectomy, with negligible morbidity and sustained improvement. Prednisone discontinuation one year or more after thymectomy has been achieved in four patients.

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A Study of Five-Year-Old Children Born After Elective Induction of Labor — W. G. McBride et al (The Women's Hosp, Sydney, NSW, Australia) *Med J Aust* 2:456-459 (Oct 1) 1977.

A controlled retrospective study of some short-term and long-term effects of elective induction of labor was conducted. There did not appear to be any increase in the incidence of maternal complications during labor, or of neonatal problems in the induced-labor group compared with the remainder of the mothers in the hospital. In the follow-up phase of the study, two treatment groups of children who were delivered after amniotomy and amniotomy plus the administration of oxytocin were compared with each other, and with a control group of children born after spontaneous labor. The children were assessed at the age of five years on verbal and nonverbal subtests of a standardized intelligence scale, tests of gross motor and fine motor coordination, and auditory and visual tests. A full physical examination was also performed. No statistically significant differences nor trends of clinical interest

were found between the groups on any measure.

Suicide in Schizophrenics, Manics, Depressives, and Surgical Controls — M. T. Tsuang (Department of Psychiatry, Univ of Iowa College of Medicine, Iowa City, IA 52242) *Arch Gen Psychiatry* 35:153-155 (Jan) 1978.

This article reports suicide risk among 200 schizophrenic, 100 manic, and 225 depressive patients, and 160 surgical controls. The suicide experience was compared with that of the population of Iowa, and geographical area from which the subjects were selected. The suicide experience of the surgical controls was not significantly different from that of the general population. On the other hand, increased risk of suicide was found in all psychiatric groups except female schizophrenics. Suicide appeared pronounced during the first decade of the follow-up period, particularly in male patients with affective disorders.

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Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids).

Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

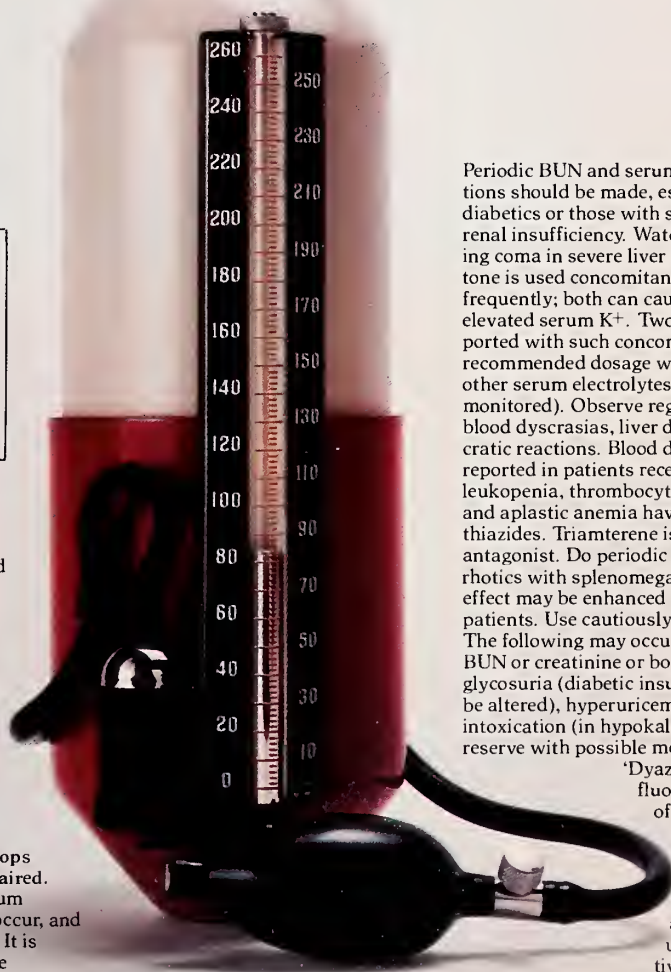
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ARMS AND THE MAN

We may have left Latin, but not really, not if you look up artery or vein or muscle in a medical dictionary. Artery refers you to pages of *arteria*, vein to *vena*, muscle to *musculus*, and ligament takes you to *ligamentum*. And if we have left an old language for a new, we take refuge in nonsense English.

One phrase that gives me no rest is *lower extremity*. That's the *membrum inferius*, and that is the lower limb, which in turn means thigh, leg, and foot. An extremity is an arm or leg. The arm goes from the shoulder to the elbow, but popularly from shoulder to hand, and it is the *brachium*, too.

The crus is the leg, from knee to foot, the *extremitas inferior* is the *membrum inferius*, the leg is the lower limb, especially from knee to foot. The upper extremity is the *membrum superius*, or upper limb: arm, forearm, and hand.

When I say leg, I mean the whole thing, hip to foot; and I think the arm goes from shoulder to hand; *the lower extremity* is an affectation. Women don't have lower extremities, they have legs.

A lincture is an electuary. And I have read that *the chest tube became self-avulsed*. It fell out is better English and it's honest. I wouldn't like to hear my doctor tell me, it became self-avulsed. We all know what *it fell out* means.

Our patients surely recognize nonsense. Is it that we say leg, but we write lower extremity? It's time we wrote the way we talk, and did both honestly.

—F.C.

HOWEVER

One word I can do without is *however*. It is annoying to read the report of a physical examination where the physician writes, examination on the left shoulder was unremarkable; *however*; whereupon he goes on to tell you that the examination was not unremarkable at all. Sometimes the report

reads, examination of the skin was completely normal, *with the exception of*; and then you learn that something was wrong with the skin.

If the knee was swollen and there was crepitation (crepittance is not a good word), we should not be told that the knee was normal, with the exception of whatever the examiner finally found. If the thyroid was obviously enlarged, it is irritating to read that the neck was normal, *however*.

If the reader reads swiftly, he may easily seize on the words normal or unremarkable, and not notice the *however*, and with the exception of.

The only explanation I can find for this strange custom is this, that the examiner could not make up his mind as he looked at the patient or as he wrote or dictated, but even this does not convince me. I can find no defense of this strange reporting. If there is spasm, all is not well, if there is bleeding, the examination is not completely normal, and if the patient is short of breath, the test cannot be called unremarkable. *However* reminds me of the detective in the suspect's home, who says I was just passing by, everything is fine, and goes to the door and then says, O by the way, and then asks what he really came to ask; everything was not fine, he did not just happen to be passing, he came to ask a fatal question.

Put down what you find, but if you must remark that there is tenderness, do not say unremarkable, if there is herniation, do not call it normal. Unremarkable, however, and normal with the exception of has no place in a medical report, or anywhere.

—F.C.

WHAT DOES GRADE TWO MEAN

When the examiner says in his report that muscle strength is 4/5, what does he mean? When the report states that there is grade 2 atrophy, what does the patient have? And what is meant by a grade 3 murmur?

For some things, examiners use a scale of 4, and for other parts of the body, a scale of

5, or even 6 seems to be suggested, while it appears that different testers use different scales of measurement. Grade 1 on a scale of 4 or 5 seems to me to be slight, whatever the abnormality is. But I have read that there was minimal wasting to a 4/5 extent.

I suggest that we all get together and use the same scales, that everything, if we are going to use this system, be measured on a scale of 4, and not 5 or 6. The number is not overly important, but we must seize on *one* number. I think we should all know if grade 1 means slight, as I suppose it to be.

We need uniformity, and a system whereby medical reports would be intelligible, so that the reader will know exactly what the examiner found and what he means. Perhaps the percentile system would be better, and we could speak of 20 percent weakness or atrophy.

Maybe English is what we want, and we can describe muscle strength as good, or weakness or atrophy as slight, and a murmur as loud or soft. What we need is common sense.

—F.C.

SPEAKING OF DYING

Life is a phenomenon and so is death. But while we speak glibly of life, we have an enormous respect for death. We think we have some small understanding of the one, but none of the other. And in this connection, there is one word for life, but death is rich in synonyms. Death has been named the Pale Sweetheart, sleep is called death's brother.

It's curtains for him, we say, or he is gathered to his fathers. It's the end, or it's all over, or we say eternal rest or eternal sleep. He passed away is said commonly, or

simply, he left us. He died in his sleep is a softening of the blow, and sometimes we say, he is gone. In one part of the country, they say, father is all. I have read, he is with his forefathers, and he went away, or he is no longer with us, or we lost him; he gave up the ghost, or gave up the spirit. He checked out; he cashed in his chips.

All gone, has been uttered, and he is six feet under, or he was planted, and he is bringing up daisies. Some say, he is not with us anymore, or he was taken, or he was taken from us, or he is gone from our midst. Then there is gone away, he has had it, he is not here any more, and it's all over with him, may he rest in peace. He kicked the bucket; he has gone to his reward.

Here are even more synonyms: debt of nature, pass out of existence, decease, demise, perish, dissolution, pay Charon, departure, be no more, crossing the bar, go West, the great adventure, join the choir invisible, expire, quietus, go to one's last home, extinction, go the way of all flesh, the grim reaper, man with the scythe, cease to exist, Jordan, breathe one's last, Stygian shore, cessation of vital functions, and the last rest.

Life is indeed strange, but it is with us ever, and we do not think much about it. Death mystifies us, and perhaps that is why we invent so many different ways of saying that somebody has died. We cannot easily believe that someone we knew well will not be at his desk again, or will not make hospital rounds once more. And if we cannot understand it, we speak of it in so many different ways. Life is life, but we know all sorts of ways of saying that someone's life span has run out, without saying that he has died. Death, to be sure, is stranger than life.

—F.C.

Angiographic Localization and Treatment of Gastrointestinal Bleeding

OVER the last 8 years there has been increased interest in the angiographic diagnosis of gastrointestinal bleeding and its control by intraarterial infusion of vasopressin. For the purposes of this discussion, it is best to divide bleeding into 3 types: venous bleeding from esophageal varices, small vessel arterial bleeding from gastritis, diverticulosis or the Mallory-Weiss syndrome, and large vessel bleeding from duodenal ulcers. The diagnosis of the site of bleeding depends on demonstrating extravasation of contrast material into the bowel following an arterial injection of the bleeding vessel. We are not able to see the extravasation in patients with bleeding esophageal varices because of the dilution of the contrast material but we believe an angiographic study is still necessary in the patients to demonstrate superior mesenteric and portal vein patency. Since there is a 10% association of portal vein thrombosis with cirrhosis, it is important to assess the portal vein prior to surgery.

While experimentally, extravasation has been shown in arterial bleeding with as little as 1.5 units blood loss per day, clinically it takes at least 3 units of blood loss per day to demonstrate extravasation into the bowel. For this reason, we do not routinely study patients with arterial bleeding, looking at the site of extravasation, unless their blood loss is at least 3 units per day. Serial radiographs are taken for at least 30 seconds so that the capillary and venous phases of the angiogram are completed and there will not be confusion with extravasation of contrast media into the bowel. By utilizing superselective catheterization of the left gastric artery in patients with gastritis or the Mallory-Weiss syndrome or superior mesenteric angiography in patients with diverticular bleeding, we have been able to identify the bleeding site in most patients referred to our laboratory. In patients with bleeding duodenal ulcers, selective injection of contrast material into the gastroduodenal artery is preferred.

ROBERT I. WHITE, JR., M.D.

Professor of Radiology

Director, Cardiovascular Diagnostic Laboratory

Johns Hopkins Medical Institutions

Baltimore, Maryland 21205

Before angiography, endoscopy is recommended in all patients with upper gastrointestinal bleeding. In most instances, the cause of the bleeding can be demonstrated, but if the bleeding is so severe that the etiology is obscured, at least the endoscopist is able to localize the bleeding to the esophago-gastric junction, stomach, or duodenum. This is helpful in guiding our catheterization study and reduces the time of arterial catheterization and the amounts of contrast material utilized. It is quite analogous to getting a lung scan in all patients with pulmonary embolism before considering them for pulmonary angiography. The lung scan serves as a road map for our catheter placement, just as endoscopy serves as a road map for catheter placement in patients with gastrointestinal bleeding.

Vasopressin is the drug of choice for control of gastrointestinal bleeding. This posterior pituitary extract acts independently of the autonomic nervous system in causing an intense arterial vasoconstriction. In patients with bleeding esophageal varices, vasopressin is infused into the superior mesenteric artery in order to reduce superior mesenteric blood flow. Since liver resistance is not changed, it is assumed that the transient reduction in superior mesenteric venous flow accounts for a lowering of portal pressure by reducing portal venous blood flow.

Since the incidence of rebleeding in patients with esophageal varices is great, and since the mortality is so high from the first bleeding episode, all patients with bleeding esophageal varices are infused once the diagnosis is established by endoscopy. We

have been successful in controlling bleeding in patients with esophageal varices 80% of the time but unfortunately, when the vasopressin is tapered, approximately one half of these patients bleed again and require semi-emergency shunting procedures. We now look upon vasopressin infusions for bleeding esophageal varices as an angiographic Sengstaken which is safer than balloon tamponade. The infusion of vasopressin allows time to evaluate the patient and to restore blood volume; if the patient rebleeds, then an emergency shunt can be performed with the patient's condition stabilized.

In arterial bleeding from gastritis or diverticulosis, vasopressin acts to constrict directly the bleeding artery. Control of diffuse hemorrhagic gastritis and bleeding diverticula of the colon have been achieved in 80% of patients referred to us. This has been a permanent control, and the patients have not rebled. I would add that before resorting to infusion of vasopressin in patients with arterial bleeding, we feel it is important to give them a chance to stop on their own, since a significant percentage of these patients will stop spontaneously.

Unfortunately, large vessel bleeding from duodenal ulcers is less easily controlled by vasopressin infusion. Most investigators have indicated 50% or less success rate in controlling bleeding duodenal ulcers with vasopressin infusion. This has led to a recent interest in embolizing the gastroduodenal artery in patients with bleeding duodenal ulcer with autologous blood clot or Gelfoam. In patients who are poor surgical candidates for duodenal ulcer surgery, embolization of the gastroduodenal artery has offered an attractive alternative. Both the clinical and experimental results from our laboratory and others have indicated that arterial embolization is a successful way of controlling hemorrhage from duodenal ulcers. Arterial embolization technics have also been used successfully to control bleeding from renal trauma or pelvic fractures. It is anticipated that over the next several years arterial embolization technics will become more widespread in controlling large vessel bleeding in patients who are poor surgical risks.

Vasopressin infusions are tapered quite slowly on bleeding esophageal varices or

small vessel arterial bleeding has been controlled. In most instances, this means that the patients are infused over a period of at least 3 days before removing the catheters. It is recommended that all patients undergoing arterial infusion be monitored in the Intensive Care Unit. Femoral artery complications, consisting of thrombosis or hematomas, and infection have been reported rather infrequently. Vasopressin, even in the low dosages employed in arterial infusion therapy, is a potent coronary vasoconstrictor and rarely angina and arrhythmias have occurred in patients with ischemic heart disease during infusion.

It is also our strong feeling that this form of therapy is best employed by a team of physicians, including the vascular radiologist, internist, or gastroenterologist, and surgeon. The cooperation and consultation between these physicians has led to a high success rate of controlling bleeding in our own Institution and also in the community hospitals in our area where this therapy has been attempted.

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FOR CORRECTIONS SEE
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Health Behavior of Children — A Predictor of the Nation's Health?

Part II

SAMPLE

The Health Behavior Inventory was administered in the two major school districts during the first two weeks of December, 1975. From a total population of 4,593 a random sample of 791 pupils was selected. This sample represents 17% of the total population or approximately one out of six pupils.

The column on the right in Table I is a ranked description of the inventory categories from high to low. The remaining columns reflect the average numerical amount of positive or negative deviation from the national norms found in the Health Behavior Inventory. A difference bearing a plus sign (+) and a minus sign (-) express the relative direction of deviation from the national norms; for instance, the numerical plus signs indicate the average scores are above the national norms.

MATILDA S. McINTIRE, M.D.

INTERPRETATION OF TABLE I

According to the Health Behavior Inventory Manual for elementary level, an interpretation of group scores can be accomplished through the use of the Percent of Preferred Responses to each content area. Through the use of these data, local and national scores can be compared to discover the relative standing of each group. This comparison will reveal the areas of special note for each content area.

The females sampled from Districts A and B had the highest negative deviation for "Personal Cleanliness" and "Personal Health." District B's deviation on the scale for "Personal Cleanliness" was — 15.80, which was over twice as high as District A

Behavior	District A Rank	Deviation From National Norm	District B Rank	Deviation From National Norm	Combined Districts Rank	Change From National Norm
Female						
Safety	1	+ 6.80	1	+ 8.90	1	+ 7.10
Infection/Disease	2	+ 5.70	2	+ 4.10	2	+ 5.50
Community Health	3	+ 2.70	3	+ .80	3	+ 1.90
Dental Health	4	+ 2.10	4	- 1.20	4	+ 1.90
Nutrition	5	- 2.10	5	- 2.40	5	- 2.50
Mental Health	6	- 2.60	6	- 2.80	6	- 2.70
Personal Health	7	- 2.80	7	- 4.70	7	- 2.70
Personal Cleanliness	8	- 6.60	8	- 15.80	8	- 7.90
Male						
Infection/Disease	1	+ 7.30	1	+ 3.50	1	+ 6.40
Dental Health	2	+ 5.40	2	+ 1.90	2	+ 4.50
Community Health	3	+ 5.30	3	+ 1.30	3	+ 4.50
Safety	4	+ 2.80	4	- 1.00	4	+ 2.90
Mental Health	5	+ 1.70	5	- 1.80	5	+ 1.70
Nutrition	6	0.00	6	- 4.10	6	- .50
Personal Cleanliness	7	- 1.50	7	- 5.40	7	- 3.00
Personal Health	8	- 2.80	8	- 13.00	8	- 3.10
Total						
Infection/Disease	1	+ 5.90	1	+ 5.70	1	+ 5.40
Community Health	2	+ 4.40	2	+ 2.20	2	+ 4.20
Safety	3	+ 4.00	3	+ .30	3	+ 3.60
Dental Health	4	+ 3.60	4	- .80	4	+ 3.00
Mental Health	5	- .70	5	- 1.40	5	- .50
Nutrition	6	- 1.60	6	- 3.90	6	- 1.90
Personal Health	7	- 2.80	7	- 4.90	7	- 3.0
Personal Cleanliness	8	- 4.60	8	- 14.9	8	- 6.0

which had a negative deviation of -6.60. For the females the highest positive deviations for Districts A and B were in the content areas of "Safety" and "Infection/Disease" show the highest positive deviation. All of the remaining health behavior categories show very little deviation from the national norms. If a single problem area had to be designated for concern it would be "Personal Cleanliness" especially for District B.

For the males sampled the patterns are somewhat different from the females. While the females manifest the highest positive behavior scores for "Safety," the male deviations for this health behavior category were only slight. "Personal Health" turned out to have the highest negative deviation for males, with District B's deviation of -13.00 being considerably higher than District A at -2.80. The highest positive deviation for the males in Districts A and B was for "Infection/Disease," with District A scoring approximately twice as high as District B. District A also scored comparatively higher on the scale for "Dental Health" and "Community Health." On the combined scores for males, the "Personal Health" and "Personal Cleanliness" categories manifest negative deviations, while the three behavior categories of "Infection/Disease," "Dental Health" and "Community Health" were comparatively higher in the positive direction. If a single problem area had to be designated for concern it would have to be "Personal Health," especially for District B.

The total scores at the bottom of Table I reveal that "Personal Cleanliness" stands out as the health behavior area requiring the most attention, especially for District B. For District A, "Infection/Disease," "Community Health," and "Safety," are highest on the positive scale, while "Infection/Disease" is highest for District B.

The limitations of this test were particularly recognized by the educators and it was assumed that the methodology was valid, although it was noted that the process needed updating. There were no problems in giving the test, and there were no complaints from principals, teachers, or pupils. The test was given as part of the education program.

In summary, according to the results of the Health Behavior Inventory two areas stand out consistently at the negative end of the scale for males/females, combined scores, and Districts A and B; they are "Personal Cleanliness" and "Personal Health." The health behavior categories most consistently showing a positive deviation on the scale are: "Infection/Disease," "Safety," and "Community Health."

In addition, the educators, physicians, and members of the Health Service Agency developed a greater understanding of each others needs and objectives. There was a helpful spinoff in that the health agency was able to provide the educators additional health education materials, especially the audio-visual type. Further recommendations were made to use the findings of this study to prepare media presentations that would be used for P.T.A. programs.

It is interesting to speculate why our results should be what they were in a highly productive and financially stable area of the country where we have neither the extremes of poverty nor wealth. We have no massive slum area, marked malnutrition, or large areas of pollution. One can only conclude that the children are the mirror of the parent's life style. The state slogan is "Nebraska — the good life." Will it be thus health-wise when this generation of children are grown?

Can health behavior of children be a major predictor of the future of the nation's health? The results of this study demonstrated that children are reflecting the life styles of adult patterns. Personal health, personal cleanliness, and nutrition rank the lowest. If progress is to be made in the health status of the nation, health education and behavioral motivation must be strengthened in the schools. Adequate resources and personnel coupled with health as a major subject should be given the same status as the rest of the academic curriculum. We must capitalize on the potential of children to develop healthful ways of living coupled with the collective decisions to control and abate such problems as pollution and injury control. In times of war, governments become past masters at behavioral control and motivation to keep the war effort going. The advertising media can convince children and adults to

buy or do almost anything. As Blendon has stated,¹⁶ today's philanthropic dollars have supported projects that increase long term investment or support consumer consumption. If foundations want to continue to support investment programs, what better program to invest in than the health behavior of children? The current health education boom presents numerous problems, including quick, cheap panaceas, yet holds the potential for positive results. To improve health behavior in a free society is extremely complex and difficult. The fulcrum point may be the balance between freedom and health. With decisions on health in the hands of the naive public who want instant service, instant cures, and instant success the absence of health education and motivation has reaped its harvest.

Health behavior and living patterns developed from within should be the goal for child rearing. If pediatricians do not take the lead in health education for children, who will? As Heagarty has stated,¹⁷ "Life-style change — A difficult challenge." Will Hygeia always be the mythological daughter of Asclepius or will she rise to more celestial heights?

QUO VADIS for health education?

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The Puzzling Picture of Gonorrhea in Pediatrics

PART I

GONORRHEA is the most common reportable communicable disease in the United States at the present time, and has reached what most experts consider epidemic proportions. The serious complications of gonorrhea are becoming increasingly common in the pediatric age group, and these often present with confusing diagnostic pictures.¹ Unfortunately, most physicians who provide primary care for children and adolescents are unaware of the variety of presentations of gonorrhea in children, or are unwilling to consider gonococcal infections in their differential diagnosis of an acutely ill child. In 1974 in the United States, there were 11,510 cases of gonorrhea reported in children less than 14 years of age, with 248,757 cases in the 15-19 year age group.² While the overall incidence of gonorrhea in Nebraska is less than the national average, in 1975 there were 36 cases of gonorrhea reported in children under 14 years of age, and 41 cases reported in 1976 in the same age group.

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Because of the striking variability of the clinical presentations of gonococcal infections in the pediatric population, we have reviewed the incidence of reported cases of gonorrhea in Douglas County and in Nebraska for 1975-1976, and present several interesting patients who have been seen at Creighton University School of Medicine recently.

Incidence of Gonorrhea in Pediatric Population

In 1975, seven cases of gonorrhea were reported in Nebraska in children from 0-9 years of age, and three cases in the same age

TABLE I

Reported cases of gonorrhea in children and adolescents in Nebraska, 1975 and 1976*

Age	1975			1976		
	Males	Females	Total	Males	Females	Total
0-9 years	1	6	7	1	2	3
10-14 years	3	26	29	12	26	38
15-19 years	<u>365</u>	<u>778</u>	<u>1143</u>	<u>380</u>	<u>728</u>	<u>1108</u>
0-19 years	<u>369</u>	<u>810</u>	<u>1179</u>	<u>393</u>	<u>756</u>	<u>1149</u>

*Data obtained from the Division of Venereal Disease Control, State Department of Health, Lincoln, Nebraska.

TABLE II

Reported cases of gonorrhea in children and adolescents, Douglas County, 1975 and 1976*

Age	1975			1976		
	Males	Females	Total	Males	Females	Total
0-9 years	1	5	6	2	1	3
10-14 years	2	24	26	10	21	31
15-19 years	<u>226</u>	<u>480</u>	<u>706</u>	<u>221</u>	<u>464</u>	<u>685</u>
0-19 years	<u>229</u>	<u>509</u>	<u>738</u>	<u>233</u>	<u>486</u>	<u>719</u>

*Data obtained from Venereal Disease Control Office, Douglas County Health Department.

group reported in 1976. (Table I) All except one of the cases reported in 1975 and 1976 in this young age group came from Douglas County. (Table II) As can be seen from Tables I and II, there is a significant increase in incidence in the age group in which sexual activity might normally be expected to account for the spread of gonorrhea, with a very striking increase by late adolescence, as reported in the 15-19 year age groups. A total of 1,179 cases of gonorrhea were reported in the state in children and youth in ages 0 through 19 in 1975, and 1,149 cases in 1976. Based on the estimated 564,000 children and youth of ages 19 and under in the State of Nebraska, the incidence rate is 204 per 100,000 population, or 0.20% of children and adolescents in the state. From another perspective, 26% of all cases of gonorrhea reported in the state of Nebraska in 1976 were in the age group of 19 years and under. More surprising is the fact that 62% of these cases were reported from Douglas County, which is a disproportionate percentage of the total population of children and youth in Nebraska.

CASE SUMMARIES

CASE 1: Gonococcal conjunctivitis

A 4 pound, 3 ounce male infant was delivered following precipitous labor and delivery at 33 weeks gestation. The infant did well initially, but became jaundiced on the second day of life and was placed under phototherapy. He developed conjunctivitis with a purulent discharge on the third day, and culture of the discharge grew out *Neisseria gonorrhoeae*. While awaiting culture reports, the infant was started on topical antibiotic ophthalmic drops, but upon receipt of the culture report, he was treated with penicillin G, 50,000 units intramuscularly every 12 hours for 6 days with prompt resolution of the infection. The mother was subsequently cultured and found to be positive for *Neisseria gonorrhoeae*.

Comment: Ophthalmia neonatorum has long been recognized as a serious illness and a common cause of blindness in the past. With the onset of the Crede treatment with topical silver nitrate drops in the 1880s, the incidence of gonococcal ophthalmitis decreased dramatically from involvement of

10% of live births to less than 0.4% of births.⁴ The subsequent introduction of other antibiotic agents, such as neomycin, erythromycin, and penicillin were proven to be as effective but probably no more effective than silver nitrate. With mandatory prophylactic treatment at the time of delivery, the incidence of gonococcal conjunctivitis and ophthalmitis reached a low of 18 cases/100,000 live births in 1969.⁴ Subsequently there has been a marked increase in the incidence of gonococcal eye infections in neonates in spite of almost universal prophylaxis with silver nitrate or equivalent therapy. The appearance of penicillinase-producing strains of *N. gonorrhoeae* should further limit the use of penicillin eyedrops for the prevention of gonococcal ophthalmia. Not only are penicillin eyedrops potentially sensitizing, but they would be ineffective against resistant strains.

At the present time, any infant who develops a purulent conjunctivitis in the neonatal period should have a gram stain made of the discharge and Thayer-Martin cultures obtained. Recommended treatment for gonococcal ophthalmia in neonates at the present time consists of frequent saline irrigations, installation of topical antibiotic ophthalmic drops, and administration of aqueous crystalline penicillin G, 50,000 units/kg/day in 2 or 3 doses parenterally for 7 days.³ Concurrently, investigation of mother and other possible sources of infection should be carried out, and appropriate therapy instituted to prevent reinfection or spread of gonorrhea to other infants.

CASE 2:

A three year old male was seen in the emergency room of Saint Joseph Hospital for evaluation of swollen, painful penis with purulent, bloody urethral discharge. The child had been previously well until onset of dysuria and penile swelling 24-48 hours before being seen. Gram stain of the discharge showed innumerable gram negative intracellular diplococci, and Thayer-Martin culture subsequently confirmed the organisms to be *Neisseria gonorrhoeae*. On further questioning of the mother, she had noted at least one incidence of "playing" by slightly older children, and also reported that

the child was cared for by an adolescent baby-sitter. Cultures of the mother and immediate family members were all negative. The baby-sitter could not be located for culture. The child was treated with probenecid, 0.40 grams orally, and aqueous procaine penicillin G, 1.2 million units intramuscularly at the time of the initial visit. He was also placed on ampicillin 250 mg. q.i.d. by mouth, and had gradual resolution of dysuria, penile swelling, and urethral discharge over the subsequent 48 hours.

Comment: In the past, bloody purulent urethral discharge and penile swelling in the young male would have been considered prima facie evidence of foreign body insertion into the urethra. However, it should be noted that oral-genital contact or genital-genital contact in the young child is surprisingly frequent. Careful but diplomatic evaluation of family members and other possible contacts with both pharyngeal and genital cultures for gonorrhea and evaluation for possible sexual abuse is essential in the management of the young child with gonorrhea. An increasing incidence of gonococcal pharyngitis is reported among young children, which has led to the recommendation that a Thayer-Martin pharyngeal culture should be obtained in the child with persistent pharyngitis not due to Group A beta-hemolytic streptococcus, regardless of the age of the child.

CASE 3:

A 15 year old female, known juvenile diabetic, was admitted to the hospital for evaluation of possible acute rheumatic fever. She gave a history of swelling and tenderness of the right knee of two days duration, and a history of sore throat one week before admission. The right knee was hot, swollen, and erythematous, with marked tenderness to palpation and movement of the joint. Cardiac examination was unremarkable, but pelvic examination revealed evidence of erythema of the cervical os with purulent discharge. Shortly after admission, she also

developed painful swelling of the left wrist, scattered one-millimeter papulopustular lesions on extremities and back, and multiple erythematous 1 cm flat lesions on the right hand, trunk, and dorsum of the left foot.

Joint aspiration of the right knee was performed, obtaining a small amount of fluid with a few PMNs. The cervical discharge showed gram negative intracellular diplococci, and a Thayer-Martin culture was subsequently reported positive for *Neisseria gonorrhoeae*. The admitting diagnosis was changed from that of acute rheumatic fever to that of gonococcal arthritis with classical manifestations of the gonococcal arthritis-dermatitis syndrome (GADS). The patient was treated with intravenous penicillin, 12 million units per day for three days, and subsequently followed with oral ampicillin, 500 mg. q.i.d. for 10 days. She had prompt resolution of her symptoms within 48 hours after onset of penicillin therapy.

Comment: The gonococcal arthritis-dermatitis syndrome (GADS),⁵ is reported as a complication of 3% of cases of gonorrhea, being most prevalent in females between the ages of 16 and 20. The acute onset of arthritis and nonspecific erythematous rashes often leads to the confusion with acute rheumatic fever. The more typical erythematous macular lesions which progress to purpuric or hemorrhagic papular lesions or to the development of vesiculopustular lesions are important for establishing the proper diagnosis. It is difficult to isolate *N. gonorrhoeae* from the skin lesions, although they may occasionally be seen on gram stain. The diagnosis is largely based on the ability to isolate the organism from vaginal, cervical, rectal, blood, or joint fluid cultures. The response to penicillin therapy is dramatic as was noted in this case.

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Reference 1. Data on file, Mead Johnson Pharmaceutical Division.

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Theophylline dosage may be cautiously increased to 2000 mg/24 hour in adults and 9 or 10 mg/kg every 6 hours in children. Monitoring of serum theophylline levels at higher dosages is recommended.

Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theo-

phylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 µg/ml.

How Supplied: Quibron Elixir: Bottles of 1 pint and 1 gallon. Quibron Capsules: Bottles of 100 and 1000 and unit-dose packs of 100. Quibron-300 Capsules: Bottles of 100.

Down Memory Lane

1. The basic science boards of examiners should be granted complete authority in the examinations in the basic sciences.

2. The skin tuberculin tests have no value in the diagnosis of adult tuberculosis.

3. It is reported that 2000 English speaking physicians pursued postgraduate studies at Vienna during the past four years.

4. Most medical men in a life-time have but one wife: take that one to the annual meeting.

5. Consider all prostatics potentially bad risks.

6. The average mother considers crying in her baby a sign of hunger and usually hurries to the crib to appease the crying infant by offering the breast.

7. National Hospital day occurs May 12, and should be generally and effectively observed.

8. A committee of physicians from the Lancaster County Medical Society brought a severe indictment of the sanitary conditions of the Lincoln City Jail.

9. Seven hospitals are approved for internships by the Council on Medical Education and Hospitals, and one is approved for residencies in specialties.

10. At the present time there are so many specialties and specialists, that the poor bewildered country doctor sometimes really wonders if he has any right at all to classify himself as a doctor.

Nebraska State Medical Journal
May, 1928.

President's Page

BEING LITTLE BIT PRESIDENT

All good things must come to an end and so goes the Presidency of the Nebraska Medical Association. A colorful year has passed and I have had the great opportunity to witness the success of the malpractice bill, help fight the battle of the new hospital licensure regulations, extoll the virtues of ophthalmology, sustain our concerns about PSRO, tried to crush the viper, laetrile, saw the surfacing of cost containment and certificate of need legislation as well as the continuing pressure of National Health Insurance to mention only a few of the concerns of the past year. The work never ends but I see in the future the brilliant and capable successors ready to take over.

What about the future of the society? Of medicine? The society will be in good hands and as far as the future of medicine, I am firmly convinced, it is here to stay. People will continue to get sick, seek medical advice and expect that one to one patient-doctor relationship. The only real change that has occurred in my time is the method of remuneration. I have seen the price of a doctor's office call change from a pound of butter and a couple dozen eggs to a price the patient could care less about because he feels someone else is paying the bill. I pray, however, that there will never be a change in the one to one patient-doctor personal relationship.

Have you ever sat in a mountain cabin, looking out the window during the spring thaw? Well I have. The sun was bright enough to melt the snow on the roof and drop by drop the water fell to the ground below and together with the many other drops, account for the crystal clear mountain stream flowing a short distance away to go forth to the big sea miles away. This is the feeling I had as president of Nebraska Medical Association. All you members out there are likened to the little drops of water, some contributing little others much more to the mainstream of the service, social, economic, political steam of medicine that must pass through and contribute to the main-

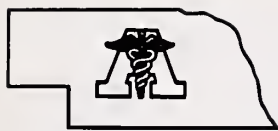


stream which is the office of the president and on to greater depths namely the national level of activity, the great sea. Without each drop this office could not survive. I am grateful for the input I received to make the office of president viable. Continue your valuable work. Never let the crystal clear mountain stream dry up.

Being President is one of degree in membership in the Nebraska Medical Association. As President I have been a small part of the Nebraska Medical Association. Other officers are also a little bit of membership of Nebraska Medical Association. Every last one of you that belongs is a part of the membership of the Nebraska Medical Association. Now turn this around. Every member is a bit of the President if he participates in the activity of the society. Now that I am stepping down and will join the rest of you as members, I hope to maintain an active role in medical care and be a bit of the Presidency of the Nebraska Medical Association.

To conclude, I want to thank everyone who made my presidency possible and for all the help and cooperation I received during my term at office. It has been a most educational and rewarding experience and I thank all of you.

Arnold Lempka, M.D.



The Auxiliary

PROJECT BANK — Super Source for County Projects

The PROJECT BANK is our National Auxiliary's information resource. Housed at national headquarters, it stands as a center from which state and county auxiliaries can obtain materials on community service projects which have been developed and implemented by other auxiliaries across the country.

A Project Bank Catalog of thirteen categories has been developed. Each program in the Project Bank has been assigned a number. Sub-categories keyed to the catalog index make it very easy to find desired material in any given area of interest.

Twenty volumes of the Project Bank have been distributed in Nebraska and are available through county auxiliary presidents, Area Councilors or Project Bank Chairman. Auxiliaries are urged to use this as a resource for project ideas, not only for themselves but for allied community groups.

All Auxiliary members are urged to submit project reports to the State Project Bank Chairman for her review. Projects then are submitted to the National Area Counselor for her consideration, and finally sent to the National Office for their approval and acceptance for publication.

Nebraska Auxiliaries' Participation

During its first years of circulation, four of five projects submitted to National Office were selected for inclusion in the current Bank. They are as follows:

ADAMS COUNTY:

"So You Are Growing Up" HE-9-2
A Health Education Course

BUFFALO COUNTY:

GEMS Program CY-1-10
Good Emergency Mother Substitute

LANCASTER COUNTY:

Food Bazaar FR-7-31
(Fund Raising for Philanthropies)
and
CPR HE-4-7

The following Auxiliaries have submitted project reports during the current year:

ADAMS COUNTY:

Menopause Seminar
and
Practical Preparation for Death

BURT-WASHINGTON:

FACES, Inc.
Family And Child Emergency Service

DAWSON COUNTY:

Allied Careers Scholarship Program

GREATER OMAHA:

Swedish Smorgasbord
(AMA-ERF Fund Raising)
Talking Books
Services to the blind.

HALL COUNTY:

Rape Awareness Seminar

SCOTTSBLUFF COUNTY:

Hospital Visitation Program
(with Western Nebraska Hospital
Auxiliary)
Book Cart for County Jail Inmates
(with AAUW)

6TH COUNCILOR DISTRICT (YORK):

Doctor Appreciation Week

Compliments from National Project Bank Officer:

We have been advised that all of these projects will be included in the supplement to be published this summer. Of our efforts for the year, the North Central Regional Counselor, Mrs. George Wilson has said: "Nebraska has done an outstanding job in the area of Project Bank . . . and far exceeds all other states in my area for performance."

Thank You, Nebraska Auxilians.

Mrs. Harry D. (Dorothy) Shaffer
Project Bank Chairman 1977-1978



Mail contribution to:
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P.O. Box 30186
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Make check payable to:
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Goal for support from Medical Community . . . 150,000.00*
*House of Delegate action October 1976, recommended
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67% of the \$150,000.00 has been raised
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In accordance with the House of Delegates action* we give/pledge \$_____ for the development and maintenance of the Health Galleries.

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★ October, 1976 Resolution for gift from each physician for \$200 to support the Health Galleries.

Our Medical Schools

New Dean for U/N.

Nominations and applications for the position of Dean of the University of Nebraska College of Medicine are being sought by a search committee recently appointed by Medical Center Chancellor Neal A. Vanselow.

Dr. Kenneth Barker, chairman of the search committee, said the deadline for nominations and applications is May 15.

Others on the committee are Dr. Merrill Eaton, Jesse Edwards, Dr. Alan Hopeman, Dr. Charles McLaughlin, Dr. Judith Ramaley, Dr. Raymond Records, Dr. Jerald Schenken, Dr. Michael Sorrell, Dr. Richard Tollefson, and Dr. Daniel Wingard, all on the College of Medicine faculty.

Also serving are Robert Baker, director of the University of Nebraska Hospital and Clinic; C. R. Boughn, executive assistant to Chancellor Vanselow; Dr. Nancy Langston, associate dean of the University of Nebraska College of Nursing, Lincoln division; Dr. Sidney Stohs, College of Pharmacy professor; and James Deterding, third-year student in the College of Medicine.

A successor is sought for Dr. Perry Rigby, who will step down from the Dean's position July 1. Dr. Rigby will remain on the College faculty.

Creighton appoints Dr. Sketch.

Michael H. Sketch, M.D., professor of medicine at the Creighton University School of Medicine, has been appointed Director of the University's Division of Cardiology. Dr. Sketch fills a vacancy created by the resignation of Vincent Runco, Jr., M.D., who has served as director since 1971. Dr. Runco requested that he be allowed to step down as director so he could devote full time to teaching and clinical activities.

Dr. Sketch received both his baccalaureate and doctor of medicine degrees from Creighton University. He is a Diplomate of the American Board of Internal Medicine and the National Board of Medical Examiners and is

a Fellow of the American College of Physicians and American College of Cardiology.

Dr. Sketch has served as director of the cardiac laboratories since 1969 and as associate director of the Division of Cardiology since 1971.

Sleeping & walking.

For some people it's not a rare occurrence to go to sleep in one room and awake in another.

This ambulatory slumber is commonly referred to as sleepwalking, for which there is no known cause or cure; but a Nebraska Psychiatric Institute researcher wants to change that.

Dr. William H. Reid, a clinical and research psychiatrist, and two colleagues, Drs. Charles Levie and Iqbal Ahmed, are conducting a study to determine the effectiveness of a type of medical hypnosis in alleviating the syndrome.

Dr. Reid said he hopes to find 30 sleepwalkers who would be willing to undergo the "simple, painless and drug-free" treatment, which would be administered in six half-hour sessions by a qualified psychiatrist.

There are problems in recruiting subjects for such a study, he noted, since many people are ashamed to admit their sleepwalking partly because of a common belief that it is associated with psychiatric disorders.

"We see no correlation between sleepwalking and psychiatric disturbances," stressed Dr. Reid, who has been studying the syndrome for four years. "Ordinary sleepwalking is merely a discomfort or inconvenience like a headache.

"People may sleepwalk more during stressful periods," he continued, "but there is usually no connection with mental illness."

Another popular misconception is that sleepwalking accompanies dreams, he said.

"Sleepwalking occurs in a deeper stage of sleep, although people may awake and remember dreams. But this is because that as they return to consciousness, they pass through a dreaming stage," he said.

As for the activity itself, Dr. Reid said sleepwalking "is not really dangerous."

"Most sleepwalking is self-limiting," he said. "If a person walks into some fresh air, it wakes him up. It usually doesn't take much to bring sleepwalkers out of it."

Although relatively uncommon in adults, sleepwalking affects more men than women and encompasses all socio-economic levels. Dr. Reid said the 12 study participants thus far treated represent a variety of occupations and lifestyles.

He said the participants will be followed for approximately a year after treatment to assess its long-term effectiveness in reducing sleepwalking.

"All participants remain anonymous and all information is confidential," he said.

Any adult who sleepwalks and would be interested in participating in the study may contact Dr. Reid at the Nebraska Psychiatric Institute, 602 South 45th Street, Omaha (68106), or telephone 541-4511.

**Brief Summary of Prescribing Information
Combined TEGOPEN® (cloxacillin sodium)
Capsules and Oral Solution**

For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established. **Precautions:** The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

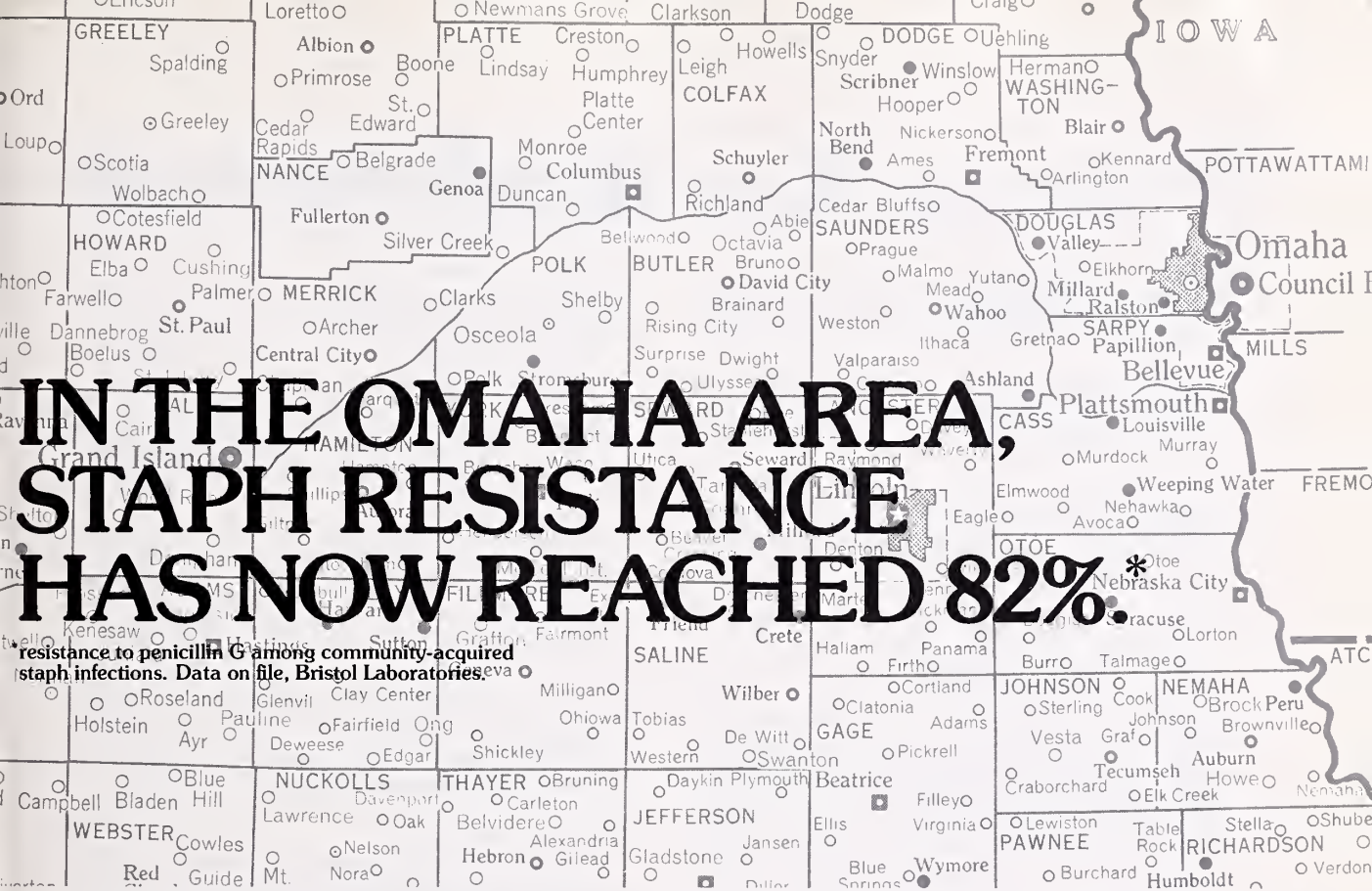
Usual Dosage: Adults: 250 mg. q. 6h.

Children: 50 mg./Kg./day in equally divided doses q. 6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

Supplied: Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100. Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

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- Effective against nonpenicillinase-producing staphylococci, beta-hemolytic streptococci, and pneumococci.†

†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *in vitro* data is unknown.

- 10 times more active against strep than staph.
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‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.



Please see brief summary

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Bergan Mercy Hospital
7500 Mercy Road
Omaha, Nebraska 68124

Rodney R. Czaplewski, M.D.
10060 Regency Circle
Omaha, Nebraska 68114

Jerry D. Edelman, M.D.
University of Nebraska Medical Center
42nd and Dewey Avenue
Omaha, Nebraska 68105

Angelito C. dela Cruz, M.D.
Friend
Nebraska 68359

David H. Filipi, M.D.
10060 Regency Circle
Omaha, Nebraska 68114

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William W. Smith, M.D.
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Omaha, Nebraska 68114

Joseph H. Washburn, Jr., M.D.
University of Nebraska Medical Center
42nd and Dewey Avenue
Omaha, Nebraska 68105

REINSTATED MEMBERS

Lawrence C. Klein, M.D.
2410 South 73rd
Omaha, Nebraska 68124

Between Cases

The Diagnosis.

I cannot explain the stiffness in the right elbow.

Quote Unquote.

A man who doesn't smile, dies.
Anon.

Definitions.

Weed: a plant whose virtues have not been discovered.
Emerson.

Words We Can Do Without.

Seminal, bemused, she's something else, word one, refurbished

Television Nonsense.

We're now coming up on ten minutes in front of the hour.

The Admission Note.

Hemoglobin: 17.4.
Diagnosis: Anemia, etiology unknown.

Department Of Prognosis.

The length of illness was once determined by the flight of birds.

It Can't Hurt You.

I remember being told that something couldn't hurt me; it was sterile. I said that carbolic acid was sterile, too, but it could hurt me. And now I read that some food grows naturally and is therefore good for

me, and I remind the ones who tell me this that toadstools grow naturally, too.

The Most Offensive Phrase Heard On TV.

We thought you'd like to know.

From The Law.

If it were true for spouses, it was even truer for unmarried fathers.
I like truer; I don't care if it's not in the dictionary.

How To Diagnosis, Impressively.

He nodded his head before speaking, remembering from somewhere in some course in law school some professor pointing out that a pause and a nod of the head before a statement somehow lends sincerity to that statement.
D. E. Fisher: The last flying tiger.

On Making The Man.

Beware of all enterprises that require new clothes.
Thoreau.

World Of Wonderful Words.

Paroxysmic, reentered.

Department Of Statistics.

About 20,000 murders were committed in the U.S. in 1975.

The Patient.

I either passed out or blacked out, I don't know which.

—F.C.

In Memoriam

*By medicine life may be prolong'd
yet death*

Will seize the doctor too.

—Shakespeare

DR. PAUL A. REED

Doctor Paul A. Reed died on October 28, 1977, at the age of seventy-eight. He was born in Milo, Iowa, on January 12, 1899.

He graduated from the University of Nebraska College of Medicine in 1924. Following a two-year internship, he moved to Deshler where he practiced until November, 1976.

He was recognized by the Nebraska Medical Association as a fifty-year practitioner in 1974.

He is survived by his wife; his son, Stephen, and wife Marilyn; his daughter, Susan, and her husband, Frederick Simpson; and five grandchildren: Andrew, Jenny and Amy Reed, and Ted and Mary Sue Simpson.

Books



Current pediatric diagnosis & treatment; by C. Henry Kempe, M.D., Henry K. Silver, M.D., and Donough O'Brien, M.D.; 1102 pages; limp cover, \$17.00; published 1978 by Lange Medical Publications, Los Altos, California 94022.

This is the fifth edition of this text; it first appeared in 1970, and new editions appear every two years. The book is divided into 38 chapters, written by no less than 51 authors. The print is good and reading is easy; there are many references, a few tables and figures,

and a good index. This reviewer is referred to in the text at great length, and in the index, so it must be a good book.

The book has been translated into Spanish, Polish, and Serbo-Croatian, and it will soon be available in Italian and French.

There is a *Handbook of pediatrics*, by Silver, Kempe, and Bruyn, but *this* book is the real text. It is large, and it is up-to-date. It is recommended.

—F.C.

Physicians' Classified

Advertisements in this column are run at a rate of twenty cents per word with a minimum of \$10.00 per insertion. Copy must be received by the fifth of the month preceding date of publication and should not exceed 50 words. Each advertisement will be taken out following its first appearance unless otherwise instructed. Where numbers follow advertisements, replies should be addressed in care of The Nebraska Medical Journal, 1902 First National Bank Building, Lincoln, Nebraska 68508.

STAFF PHYSICIAN — General practitioner to perform general examination, care, and treatment of patients or staff at state psychiatric hospital. Surgery limited to emergency first-aid care. Forty-hour week with rotating on-call duty. Salary negotiable in range of \$29,892 to \$40,272. Excellent benefits. Contact: H. D. Herrick, M.D., Superintendent, Norfolk Regional Center, Box 1209, Norfolk, Nebraska 68701. Call Collect: 402-371-4343.

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5-78

Coming Meetings

CRIPPLED CHILDREN'S CLINICS —

May 6 — Ainsworth, Elementary School
May 13 — Ogallala, Elks Lodge

NEBRASKA MEDICAL ASSOCIATION
ANNUAL SESSION — April 30 - May 3,
1978, Lincoln Hilton Hotel, Lincoln, Ne-
braska.

THE FIRST INTERNATIONAL SYMPOSI-
UM OF THE INTERNATIONAL COL-
LEGE OF PEDIATRICS — June 18-22,
1978, Finlandia Hall, Helsinki, Finland.
Plenary Sessions, Symposia, Round-table
discussions, Free papers. George D.
Maragos, M.D., M.Sc., Associate Professor
of Pediatrics, Creighton University Medical
School, Omaha, Nebraska, 68108, USA.

AMERICAN MEDICAL ASSOCIATION —
Annual Convention, June 17-22, 1978, St.
Louis, Missouri.

NEBRASKA MEDICAL ASSOCIATION
FALL SESSION — September 14-16, 1978,
Lincoln Hilton Hotel, Lincoln, Nebraska.

OMAHA MID-WEST CLINICAL SOCIETY:
46th Annual Postgraduate Assembly;
Omaha Hilton Hotel; October 30, 31 and
November 1, 1978. Write to: Lorraine E.
Seibel, Executive Secretary, Omaha Mid-
West Clinical Society, 540 Medical Arts
Building, Omaha, Nebraska 68102.

AMERICAN MEDICAL ASSOCIATION —
Interim Session, House of Delegates,
December 2-6, 1978, Palmer House, Chi-
cago, Illinois.

AMERICAN MEDICAL ASSOCIATION —
Winter Scientific Program, December 7-10,
1978, Las Vegas, Nevada.

Occupational health.

The 38th Annual AMA Congress on Occu-
pational Health will be held in Tucson,
Arizona on September 14-16, 1978. For
information contact Barbara S. Jansson,
Department of Environmental, Public, and
Occupational Health, American Medical As-
sociation, 535 North Dearborn St., Chicago,
IL 60610 (312)751-6669.

This 2½-day conference, cosponsored by
the National Institute for Occupational Safe-
ty and Health and hosted by the University
of Arizona, is open to all health professionals
and will be of particular interest to part-time
occupational physicians. Topics to be covered
include: arthritides, injuries to the extremi-
ties, confidentiality of medical records, se-
lected pulmonary diseases, chemically-
induced cellular transformations, reproduc-
tive disorders of the male/female worker and
the stresses of shift-work. A half-day work-
shop session will feature the determination
of pulmonary function, dermal patch testing,
and environmental sampling. A feature of
the second day of the Congress will be a
luncheon honoring the Physician of the Year
chosen by the President's Committee on
Employment of the Handicapped for his
outstanding contribution to employability of
handicapped people.

The conference provides up to 15 hours of
Category 1 credit toward the AMA Phy-
sician's Recognition Award. Registration fees
are \$60 for physicians, \$40 for occupational
health nurses, and \$30 for students.

Medicine

Dr. McGreer cited.

Dr. John T. McGreer, III, of Lincoln, NB,
will be cited for distinguished medical
achievements by being named a Fellow of
the American College of Radiology.

The College, a professional medical society
representing about 12,000 physicians who
specialize in radiology, will award Dr. Mc-
Greer a certificate of Fellowship during its
annual meeting and Convocation in San
Diego, April 11.

WashingtonNotes

Health insurance.

Senator Edward M. Kennedy, organized labor's champion for its brand of national health insurance (NHI), is reported backing away from his original proposal for total federal domination of health care financing.

While President Carter plans to stick by his campaign promise to labor for an Administration-backed NHI proposal, it has become clear in all quarters that the Health Security Act — the organized labor and Kennedy sponsored plan — has no chance whatsoever of passage due to its price tag alone.

The significant strategy change is designed to boost chances for enactment of a NHI bill within the next few years and to hitch labor in tandem with the Carter Administration on the issue.

The Administration is expected soon to release a position paper staking out the type of NHI plan the President wants approved.

Labor made a strenuous effort earlier to get the Administration to support its Health Security Act, but the Administration balked, telling labor leaders such a plan was too expensive and could not win Congressional endorsement.

Labor now says it will accept a NHI plan that provides a rule for private health insurance carriers, who would have been wiped out under the Health Security Act. Officials of the AFL-CIO and the United Automobile Workers accompanied Kennedy in notifying Carter of the policy reversal.

Congress has been shaken by the uproar over increasing Social Security Taxes and is reluctant to embark on any expensive new social program at this time due to the fiscal plight of the Treasury and the threat of double-digit inflation just around the corner.

Fees.

The AMA immediately branded a White House Wage-Price Stability Council report

on soaring physician fees a "political hatchet job."

"The report is built on old data and faulty research," James H. Sammons, AMA Executive Vice President said.

The report said doctor bills are increasing half again as fast as the overall inflation rate and that the situation may get worse. It also accused the AMA of trying to limit the number of doctors in practice.

The AMA has actively worked to increase the number of medical schools and practicing physicians in this country; almost 16,000 doctors are now graduated from U.S. medical schools each year, about double the number of five to seven years ago, Dr. Sammons said.

He said the data about physicians' income and fees in the report are incorrect.

The study said that two years ago the median income of physicians was \$63,000. The AMA, which yearly publishes statistical studies of medical practices, says the projected median for 1976 is \$54,000 and that the actual median before taxes, for 1975 was \$50,337.

Blue Shield.

The Federal Trade Commission has charged that the nation's Blue Shield plans are dominated by physicians — "an arrangement that may reduce competition and raise prices artificially."

FTC Chairman Michael Pertschuk told the Interstate and Foreign Commerce Committee's subcommittee on Oversight and Investigations that "— it is difficult to see how the public interest can be served by such an apparent conflict of interest."

He said that an ongoing FTC investigation has found that most of the 72 Blue Shield plans are controlled by local medical societies, other physicians' groups of self-perpetuating physicians boards set up to run the plans.

Subcommittee member Albert Gore, Jr., (D-Tenn.) said that many members of Blue Shield Boards of Directors "also serve on the boards of banks and lending institutions holding Blue Shield funds. These persons also have a direct interest in seeing that these financial institutions make a profit. I believe this practice is unconscionable and is an abuse of the health plans obligations to their customers," Gore said.

Medicare payments.

The Health, Education, and Welfare Department will release a list of all Medicare payments to all physicians despite warnings from both Congressmen and the AMA that a simple listing of dollar amounts paid to physicians, with no indication of the number of patients treated and the services provided for those payments, is essentially meaningless.

The list, to be available for public inspection, containing the names of some 300,000 physicians who provided services to Medicare-eligible patients during 1977 and reported to be some five feet thick and

costing perhaps as much as \$1 million will tell nothing about the physicians named, the kinds of care they provide, their actual earnings, or the patients they serve.

The list will not indicate, for example, that across the country the doctors actually received, in Medicare reimbursement, only about 58 percent of the amount of covered charges actually billed for providing medical services to persons whose care is paid for by Medicare.

In a letter of protest to HEW Secretary Joseph Califano, AMA Executive Vice President James H. Sammons pointed out that "There is no cost-benefit ratio in what HEW is doing. The interests of neither the public nor the profession are served by this type of reporting."

The list will not make clear that in many instances the payment for covered services made directly to patients who are then supposed to pay the physicians, but often do not. The physicians are credited by the HEW list with having received all moneys paid for services which they provided, but in countless instances they may have received only a part of it, or none of it.

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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond 6 months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss pregnancy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and

acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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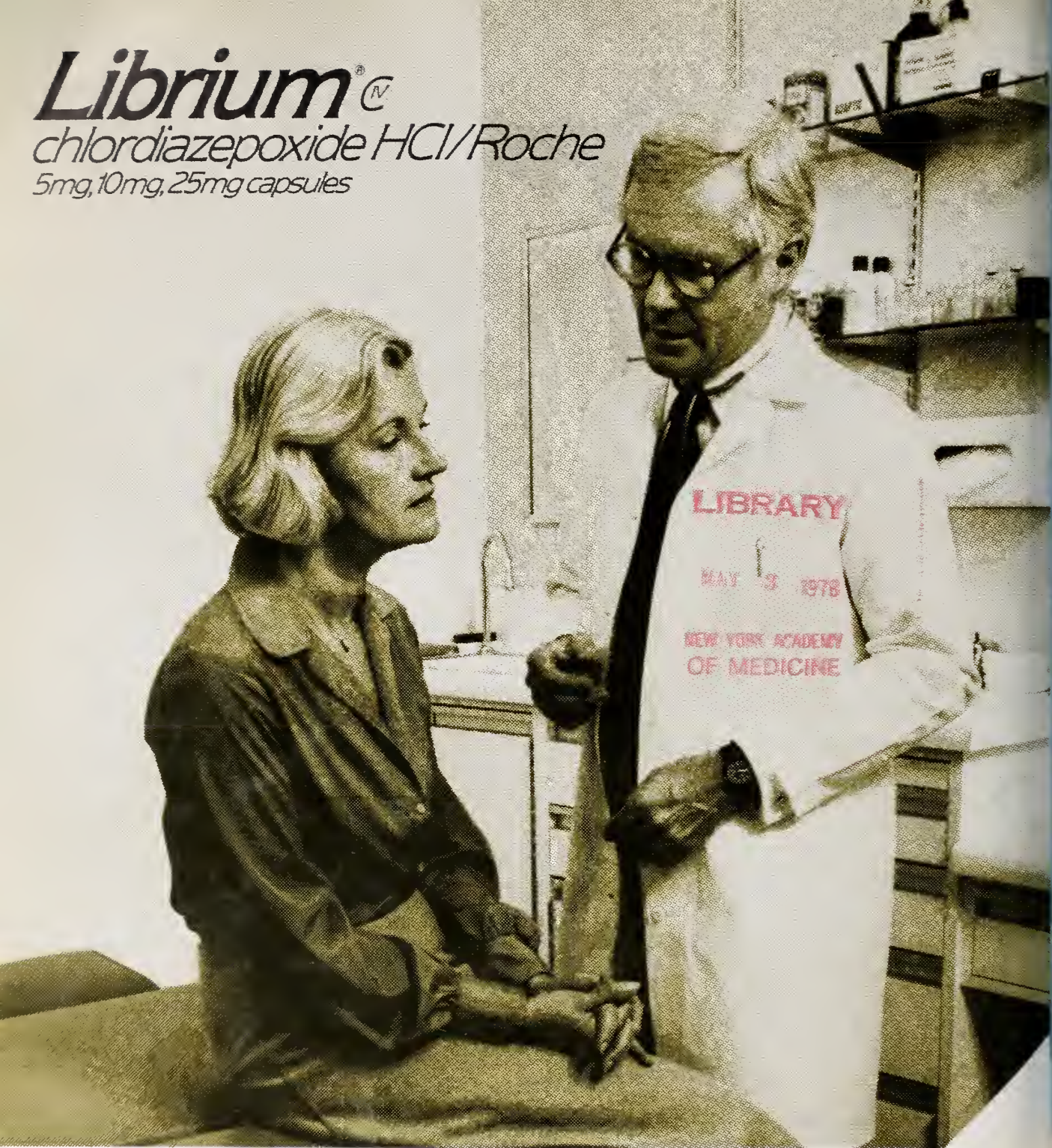


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Please see preceding page for a summary of product information.

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June, 1978

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Description: Hydrocortisone ½%, 1% or 2½% in a water-washable cream containing purified water, propylene glycol, glyceryl monostearate, cholesterol and related sterols, isopropyl myristate, polysorbate 60, cetyl alcohol, sorbitan monostearate, polyoxyl 40 stearate and sorbic acid

Action: Topical steroids are primarily effective because of their anti-inflammatory, antipruritic and vasoconstrictive actions

Indications: For relief of the inflammatory manifestations of corticosteroid-responsive dermatoses

Contraindications: Topical steroids are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

Precautions: If irritation develops, the product should be discontinued and appropriate therapy instituted

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled

If extensive areas are treated or if the occlusive technique is used there will be increased systemic absorption of the corticosteroid and suitable precautions should be taken, particularly in children and infants

Although topical steroids have not been reported to have an adverse effect on human pregnancy, the safety of their use in pregnant women has not absolutely been established in laboratory animals, increases in incidence of fetal abnormalities have been associated with exposure of gestating females to topical corticosteroids, in some cases at rather

low dosage levels. Therefore, drugs of this class should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time

The product is not for ophthalmic use

Adverse Reactions: The following local adverse reactions have been reported with topical corticosteroids, especially under occlusive dressings, burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae, miliaria

Dosage and Administration: Apply to affected areas 3 or 4 times daily

How supplied: 2½% — Tube 1 oz, 1% and ½% — Tube 1 oz and Jar 4 oz

Caution: Federal law prohibits dispensing without prescription

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Dermik

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The Nebraska Medical Journal

EDITOR-FRANK COLE, M.D., No. 13, Bishop Square
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JUNE 1978

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Illustrations should be numbered and their locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be black (India ink) on pure white. Photographs should be on glossy paper and a minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

Manuscripts (original, not a carbon) should be sent directly to the Editor at the Journal's address.

Letters to the Editor submitted for publication should be prepared as above, and must carry the notation: To be Published.

Manuscripts not accepted for publication will not be returned to the author.

Reprints should be ordered from the printer, Norfolk Printing Co., Inc., P. O. Box 278, Norfolk, Nebr. 68701.

Carcinoma of the Breast — A. C. Meyer et al
(2300 N Rockton Ave, Rockford, IL 61101)
Arch Surg 113:364-367 (Apr) 1978.

An analysis of 1,686 surgically treated carcinomas of the breast in one community showed not statistically significant differences in five- and ten-year survival for simple, modified radical, or radical mastectomy. Further confirmation was obtained by computation of relative survival which in addition showed that older women more nearly approach normal life expectancy than younger ones. Bilaterality was found to be a decreasing function of age.

Metastatic Carcinomas From Occult Primary Tumors — M. S. Didolkar et al (Roswell Park Memorial Institute, Buffalo, NY 14263) Ann Surg 186:625-630 (Nov) 1977.

From 1950 to 1973, 254 patients with metastatic cancers from occult primary tumors, comprising 0.5% of all the referred cancer patients, were seen. The average age was 59 years. Clinical presentation was commonly in the form of metastatic lesions in lung, cervical lymph node, bone, or liver. Radiological and radioisotopic investigations proved helpful in determining the extent of disease rather than the origin of primary tumor. Adenocarcinoma was the commonest type, followed by undifferentiated and squamous cell carcinomas. The origin of the primary tumor was established in 77 (30%) patients, mostly at autopsy. It was in the lung in 40% of the cases, followed by stomach, pancreas, kidney, ovary, and colon. Some correlation was found between clinical presentation and the origin of the primary tumor. Histologically different second cancers were detected in 28 (11%) patients. Overall median and five-year survival rates were nine months and 9% respectively. Longer survival was seen in patients with squamous cell carcinoma metastases, middle and upper lymph node lesions, and those who had "curative" surgery. In localized metastatic lesions, surgical extirpation should be done. Depending on the histological type of the metastatic lesions, chemotherapy and/or radiation therapy have definite roles in the management of these patients. Periodic follow-up examinations also prove valuable.

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VALIUM® (diazepam)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states, somatic complaints which are concomitants of emotional factors, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Use in Pregnancy: Use of minor tranquilizers during first trimester should always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over-sedation.

Side Effects: Drowsiness, confusion, diplopia,

hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.



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The Unsupported Arm — A Cause of Falsely Elevated Blood Pressure Readings — D. S. Silverberg et al (Chaim Sheba Medical Center, Tel Hashomer, Israel) Br Med J 2:1331 (Nov 19) 1977.

Most textbooks of physical examination fail to stress the importance of making sure that the arm is supported and relaxed when blood pressure is measured. In a survey of 40 physicians only five did this. The effect of measuring the blood pressure with the arm unsupported and supported was tested in 20 normal persons who were taking no medications. Within 90 seconds of keeping the arm unsupported the systolic pressure rose slightly (about 3 mm hg) but the diastolic pressure rose considerably (7.8 ± 1.3 SEM mm HG; $P < .05$). This represented an increase in the diastolic pressure of 10.6%. The heart rate rose by 5 beats per minute. The increase in blood pressure and heart rate is due to isometric muscle contraction causing both increased cardiac output and increased peripheral resistance.

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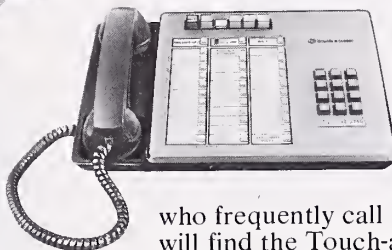
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Effectiveness of Low-Dose Continuous Intravenous Insulin Infusion in Diabetic Ketoacidosis — G. A. Edwards et al (L. L. Hill, Dept of Pediatrics, Baylor College of Medicine, Houston, TX 77030) *J Pediatr* 91:701-705 (Nov) 1977.

Twenty pediatric patients with diabetic ketoacidosis were randomly assigned in equal numbers to receive insulin either as a low-dose continuous intravenous infusion or as high-dose intermittent subcutaneous injections. Blood was obtained hourly for determinations of total CO₂ plasma glucose and osmolality, and, in previously untreated patients, plasma insulin, Serum values of beta hydroxybutyrate, electrolytes, and acetone were monitored every two hours. Plasma insulin levels were in the therapeutically effective range with each method of administration. There were no statistically significant differences in rate of correction of ketoacidosis, rate of reduction of plasma glucose, or decline in plasma osmolality. The incidence and the severity of hypokalemia were increased in patients receiving subcutaneous insulin. There was less variation in the rate of reduction of plasma glucose in the infusion group. Low-dose continuous intravenous infusion of insulin is at least as effective in treating diabetic ketoacidosis as the traditional high-dose intermittent subcutaneous injection of insulin and offers some definite advantages.

Acute Hypocapneic Hypokalemia: An Iatrogenic Anesthetic Complication — R. Edwards et al (Univ of Illinois Hosp, Chicago, IL 60612) *Anesth Analg* 56:786-792 (Nov-Dec) 1977.

Hyperventilation of patients during surgical anesthesia is a common practice in the United States. The present study re-emphasizes that serum potassium concentration is directly proportional to arterial carbon dioxide tension, and for every 10 torr decrease in PaCO₂ there is a concomitant 0.5 mEq/l decrease in potassium. Sudden and substantial levels of hypokalemia may occur during the course of a general anesthetic, and since hypokalemia is known to be capable of producing serious cardiac arrhythmias, hyperventilation should be avoided during surgical anesthesia.

Tablets

Percodan®

DESCRIPTION Each yellow, scored tablet contains 4.50 mg oxycodone HCl (WARNING: May be habit forming), 0.38 mg oxycodone terephthalate (WARNING: May be habit forming), 224 mg aspirin, 160 mg phenacetin, and 32 mg caffeine.

INDICATIONS For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS Hypersensitivity to oxycodone, aspirin, phenacetin or caffeine.

WARNINGS Drug Dependence Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of PERCODAN®, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, PERCODAN® is subject to the Federal Controlled Substances Act.

Usage in ambulatory patients Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using PERCODAN® should be cautioned accordingly.

Interaction with other central nervous system depressants Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with PERCODAN® may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Usage in pregnancy Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, PERCODAN® should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Usage in children PERCODAN® should not be administered to children.

Salicylates should be used with caution in the presence of peptic ulcer or coagulation abnormalities.

PRECAUTIONS Head injury and increased intracranial pressure The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions The administration of PERCODAN® or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special risk patients PERCODAN® should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

Phenacetin has been reported to damage the kidneys when taken in excessive amounts for a long time.

ADVERSE REACTIONS The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include euphoria, dysphoria, constipation and pruritus.

DOSAGE AND ADMINISTRATION Dosage should be adjusted according to the severity of the pain and the response of the patient. The usual adult dose is one tablet every 6 hours as needed for pain.

DRUG INTERACTIONS The CNS depressant effects of PERCODAN® may be additive with that of other CNS depressants. See WARNINGS.

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3. Minimize potential risk

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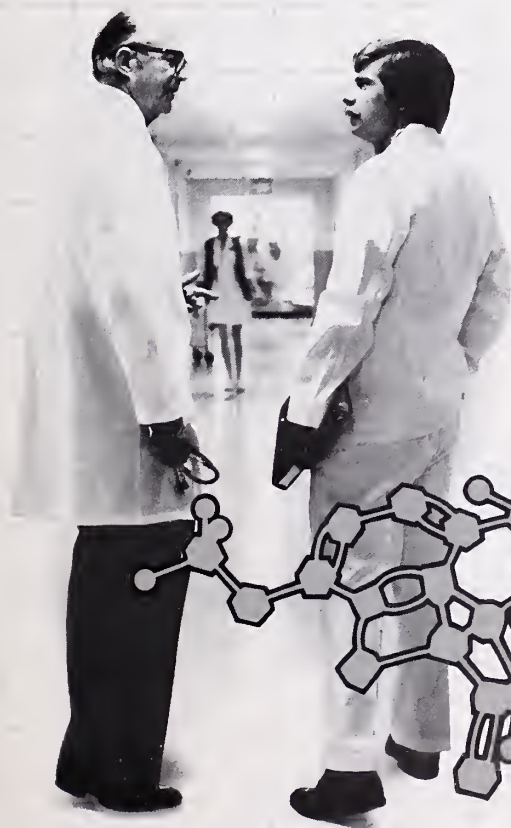
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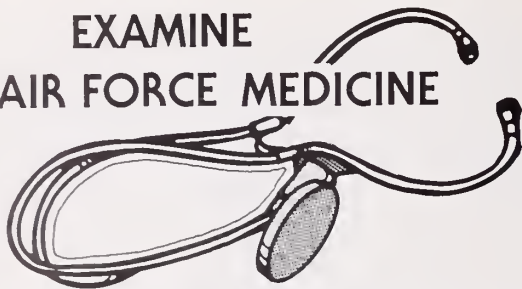
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Prognostic Factors in the Survival of 1,484 Stroke Cases Observed for 30 to 48 Months — H. A. H. Abu-zeid et al (Univ of Manitoba, Winnipeg, Manitoba, Canada) Arch Neurol 35:213-218 (Apr) 1978.

Using the life table method, 962 cases of infarction, 279 cases of hemorrhage, and 243 cases of undetermined type of stroke, occurring in Manitoba between Jan. 1, 1970 and June 30, 1971, were analyzed for factors affecting survival. Survival until Dec. 31, 1973, was adversely affected by the presence of coma or unconsciousness and the absence of localizing signs and symptoms. The prognosis was poor if the heart showed enlargement on the x-ray film or the ECG examination was abnormal. On the other hand, the presence of individual clinical entities such as hypertension, hypertensive heart disease, myocardial infarction, atrial fibrillation, or diabetes did not affect the survival rate significantly.

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PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

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Breast Carcinoma Associated With Pregnancy: A Clinician's Dilemma — G. G. Ribeiro (Christie Hosp, Manchester, England) and M. K. Palmer, *Br Med J* 2:1524-1526 (Dec 10) 1977.

The survival of 128 patients who had breast carcinoma associated with pregnancy was analyzed. Of the patients who were seen between 1941 and 1969, 88 had breast carcinoma concurrent with pregnancy; the five year and ten year survival rates were 34% and 24%, respectively. There was no special risk attached to curative treatment being carried out for operable breast carcinoma in the second half of pregnancy. Seventy-three of the 88 pregnancies ended in the delivery of a normal, healthy child. Forty patients became pregnant subsequent to definitive treatment for breast carcinoma. While 69% of this group survived five years from the start of pregnancy, 50% of the stage II patients and all of the stage III patients died within seven years.

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Survival of Patients Treated for End-Stage Renal Disease by Dialysis and Transplantation — M. R. Higgins et al (Univ of Alberta Hosp, Edmonton, Alberta, Canada) *Can Med Assoc J.* 117:880-883 (Oct 22) 1977.

The results of treatment in 213 patients with end-stage renal disease who underwent hemodialysis, peritoneal dialysis, or transplantation, or a combination, between 1962 and 1975 were analyzed, showing significantly better ($P < .01$) patient survival with the integrated therapy of dialysis and transplantation than with either form of dialysis alone. There was no substantial difference in survival of males and females but survival at the extremes of age was poorer. Analysis of survival by major cause of renal failure indicated best survival in patients with congenital renal disease. Graft and patient survival rates at one year after the first transplantation were 42% and 66%. The major cause of death in this series was vascular disease but infection was responsible for 50% of deaths after transplantation. While integration of dialysis with transplantation produces best patient survival, this is possible only when sufficient cadaver kidneys are available.

Hands as a Route of Transmission for Klebsiella Species — M. W. Casewell and I. Phillips (St Thomas Hosp, London, England) *Br Med J* 2:1315-1317 (Nov 19) 1977.

Simple ward procedures frequently contaminate the hands of intensive care unit staff with 100 and 1,000 klebsiellae per hand. Klebsiellae survived on artificially inoculated hands for up to 150 minutes, but washing with chlorhexidine hand cleanser reliably removed 98% to 100% of inoculated organisms. The introduction of routine hand-washing by staff before moving from one patient to the next was associated with a significant and sustained reduction in the number of patients with klebsiella colonization or infection (from 22.6% to 15.5% of all admissions). Staff clothing was occasionally contaminated, but ward air and dust rarely contained klebsiellae.

**Brief Summary of Prescribing Information
Combined TEGOPEN® (cloxacillin sodium)
Capsules and Oral Solution**

For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established. **Precautions:** The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

Usual Dosage: Adults: 250 mg. q. 6h.
Children: 50 mg./Kg./day in equally divided doses q. 6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

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THE NEBRASKA MEDICAL JOURNAL

YOUNG DOCTOR, OLD DOCTOR

Doctors used to grow beards to look older and experienced and wiser, and better at their trade. But that was before residency training programs, when we shaved; and now beards are back.

The older physician has probably seen more and may be more desirable. But the young doctor has just finished his post-graduate training and has done a great deal, and he is sure to be knowledgeable where new drugs and newer techniques are concerned.

The young doctor once obtained his entire medical education through preceptorship, but he now comes to the older practitioner and brings knowledge with him; and all of this makes us wonder when it comes to choosing a physician.

Beards or no beards, give me someone who reads, someone who goes to meetings, and someone who takes courses and keeps up with new ideas and events, someone whom progress does not pass by. Give me someone who reads; I don't care if he has a beard or not, just so he reads.

—F.C.

MALPRACTICE AND INSURANCE

In some cultures the patient paid the doctor only when he was well, and not when he was sick. This was based on the theory that it was the physician's duty to keep him well, and the doctor was then doing what he was being paid to do. And when he was sick, the doctor was not accomplishing his purpose, and should not be paid. This is of course the opposite of what we do here and now; the patient pays us when he is sick and not when he is well.

And what of malpractice? The *doctor* pays the *patient* when he is not well, or when he is sicker than he thinks he should be, which may not at all be sensible. We may be getting into no-fault insurance, and into national health insurance with this kind of thinking. Should the patient pay the doctor for keeping him well, and should the state

pay the patient when he is worse? Maybe this is a kind of national malpractice insurance, but why should the doctor pay money to the patient when things do not go well?

Years ago hands were cut off, but we are becoming civilized, only we have not been completely civilized. At the very worst, when the doctor has not done as well as the patient likes, other measures may be taken, and only then if they *should* be taken, but to require the doctor to pay the patient seems wrong. If the patient is to be compensated, let the state do it. Making the doctor pay money discourages students from entering medical school, it is forcing a kind of defensive medicine on us, it is too-harshly penalizing often innocent doctors, it is simply not the logical solution to the problem.

—M.D.

IS ROUTINE GOOD?

We are all individualists, and we all, doctors and the others, like to have our own way of doing things. One may apply heat, and another, cold. One may prescribe antibiotics, one may not. But how much of this is good?

In most if not all cases, the treatment of acute appendicitis is appendectomy. Fractured bones are best lined up and immobilized. Malignant tumors are removed. Patients with heart disease are given digitalis and oxygen, and are put to bed.

But we do not agree when we turn to breast cancer, or to contralateral hernioplasty in children, or to internal fracture reduction, or halothane anesthesia. We do not see eye to eye with each other when we talk of tranquilizers or coronary bypass or vitamins. This is often looked on as a healthy sign or one of growing pains, but it is time we grew up.

Routine is good: do we not all like peace, are we not all fond of good cooking, do we not abhor violence? Why do you treat hernia your way while I go mine? There ought to be a routine, and a best way of doing things,

and the charge that we are then submitting to regimentation is less serious and far less dangerous than doing something to a patient that is not the best for him.

Let us find out if open reduction is all right and do it or not; let us decide if radical mastectomy is good or not; let us decide, for all of us, if bilateral hernioplasty or exploration is a good thing to do in children; let us decide about halothane. Being rugged individualists has gone out of style. What we need now is decision-making, and we may want decision-making groups to act for us. If you see a bleeding vessel at the operating table, you ligate it; given a thousand bleeders, you do not treat them in a thousand different ways; that is chaos; there is only one right way. Breast cancer, hernia, fracture, all of these are as easy as bleeders.

—F.C.

HOW OLD?

A caption under an x-ray picture said *in a 54 year old woman*. The last two words did not fit at the end of the line, so the next line began with *old woman*.

She was not an old woman, and I do not know why we use the word so; it tells you how long it has been since the person's birth, and at the same time it implies that many

years have gone by. To speak of a two year old child and a 98 year old individual in the same way illustrates the point.

She was a 54 year woman; how much better that reads. She was 54; or if at the end of a sentence, in a 54 year woman. But not old.

—F.C.

HOW MANY COLORS CAN YOU TURN?

Some of us are white, and some are black; some are red and some yellow. And on occasion, we turn chameleon and change color. We become white with anger and with fright, yellow with jaundice, black with rage, or green with envy. We are white when we are anemic, and purple with wrath, and some have even turned orange. Reduced hemoglobin makes us blue, white is pallor. We are brown as a berry when we are sunned, or we tan; I get red. Sometimes hair can turn green.

What is remarkable is not only that we color: we blush, too; but blue becomes cyanotic, white is pallor, and yellow is jaundice.

And if you turn livid, you're black and blue or ashen, not red.

—F.C.

CORRECTION

The article "Health Behavior of Children — A Predictor of the Nation's Health?" which appeared in the April and May issues should have included James Kelsey, M.D., Michael Grush, M.D., E. James Easterling, Henry Drewes, Ph.D., along with Matilda S. McIntire, M.D., as authors.

The Puzzling Picture of Gonorrhea in Pediatrics

PART II

A 17 year old male was seen one morning for evaluation of right lower quadrant abdominal pain with rebound tenderness. A presumptive diagnosis of acute appendicitis was made and he was transferred to Creighton Memorial Saint Joseph Hospital. Subsequent evaluation revealed the presence of more extensive tenderness in the right lower quadrant, a normal rectal examination, and tenderness in the right epididymis and testicle. A history of sexual intercourse 10 days prior to admission was obtained. Within a few hours after admission, the patient developed a marked increase in pain and swelling of the right epididymis, and the presence of a slight amount of urethral discharge. A culture of the rectum and urethral discharge were both positive for *N. gonorrhoeae*. The admitting diagnosis was changed to gonococcal epididymitis, prostatitis, and urethritis, and the patient was started on intravenous penicillin, 1 million units every four hours. Forty-eight hours later, he was switched to aqueous procaine penicillin G, 600,000 units intramuscularly q.i.d. for 48 hours, and discharged on potassium penicillin V, 500 mg. q.i.d. by mouth.

Comment: The diagnosis of acute prostatitis, epididymitis, and urethritis in the adolescent male in this instance was delayed by the initial presenting complaints of right lower quadrant abdominal pain suggestive of an acute abdomen. The primary care physician who sees the adolescent or young adult male with an atypical presentation of abdominal pain should consider the possibility of acute gonococcal infections. It should also be noted that one is most likely to obtain an accurate history of sexual contact if the question is posed to the adolescent male in a setting in which he is not likely to be embarrassed by having to admit to sexual activity in the presence of his parents.

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Department of Pediatrics

and

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Assistant Professor

Department of Medical Microbiology

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Omaha, Nebraska 68178

CASE 5:

An 18 year old girl was seen in pediatric clinic with a two month history of bloody mucoid stools, increasing malaise, intermittent fever, and the recent development of bilateral cramping or abdominal pain, particularly on defecation. She had a documented weight loss of 9 pounds over the two month interval. She admitted to being sexually active and had been treated three months prior to admission for exposure to gonorrhea. Physical examination revealed bilateral lower quadrant tenderness, normal bowel sounds, no palpable abdominal masses, and the presence of marked diffuse tenderness on rectal examination. Pelvic examination showed edematous, erythematous cervix with bloody mucoid cervical discharge. She was admitted with the diagnosis of ulcerative colitis and possible pelvic inflammatory disease. Shortly after admission, a gram stain of the cervical discharge was positive for gram negative intracellular diplococci, and a Thayer-Martin culture of the rectum and cervix were positive for *Neisseria gonorrhoeae*. The admitting diagnosis was changed to gonococcal proctitis and pelvic inflammatory disease. She was started on intravenous penicillin, five million units every eight hours for five days, which resulted in dramatic cessation of abdominal pain and bloody stools. She was subsequently placed on oral ampicillin, 500 mg. q6h for seven days, and discharged to be followed as an outpatient.

Comment: While gonococcal proctitis is frequently noted in the adult patient, few re-

ports exist in the pediatric literature, and it rarely presents as a persistent illness mimicking ulcerative colitis.¹ The diagnosis in this instance was arrived at largely on the basis of a history of previous exposure to gonorrhea and the presence of gram negative diplococci in the cervical discharge. While a presumptive diagnosis of active gonorrhea can be made on a gram stain of a profuse, foul-smelling, cervical discharge, but it should *always* be confirmed by culture. While gonococcal proctitis in the male almost inevitably has as its antecedent anal intercourse, direct spread of infection from genital tract to involvement of the anus and rectum in the female may account for the development of gonococcal proctitis without anal intercourse having transpired.

DISCUSSION

The spectrum of gonococcal disease in the pediatric age group has recently been classified by Allue, et al⁶ to include not only the cases described above, but also gonococcal meningitis, gonococcal perihepatitis (Fitz-Hugh-Curtis syndrome), gonococcal pharyngitis, and the post gonococcal rheumatoid arthritis syndrome. More common than any of these remains the asymptomatic infection in both males and females. No accurate data exists on overall rates of infection in children and adolescents, but a recent study of a group of sexually-active urban adolescents in the 12-16 age group showed a prevalence rate of asymptomatic gonorrhea of 1.0% among males and 7.0% among females.⁷ The predominance of both asymptomatic and symptomatic infections in females within the pediatric age group is well recognized, and is in sharp contrast to the heavy predominance of gonococcal infections in males in the 20-24 and 25-29 age groups. Because of the rapidly escalating incidence of gonococcal infections in children and adolescents, it is urgent that physicians include gonorrhea in the differential diagnosis of any sexually-active child, and any child who presents with an unusual history of abdominal pain, dysuria, unexplained pharyngitis, or arthritis. As in adult patients, the critical principles in establishing the diagnosis in children are high indices of suspicion, the utilization of gram stain of appropriate secretions, and the obtaining of adequate cultures on Thayer-

Martin media with prompt incubation in CO₂-enriched environment.

The principles of therapy of gonorrhea in pediatric patients are not unlike those for adults. Details of current recommended therapeutic regimens for pediatric patients, as published by the Center for Disease Control in 1974, are summarized by Nelson.³ The post-pubertal child or child who weighs more than 100 pounds (45.2 kg) should be treated with dosage regimens defined for adults. The treatment of the penicillin allergic child can be difficult. For uncomplicated local disease, tetracycline may be used in the older child and erythromycin in the younger. It should be remembered that the efficacy of erythromycin in gonorrhea is unproven and careful follow-up is mandatory. Spectinomycin would seem to be an effective single-dose alternative to penicillin, but it is not FDA approved for children. Informed consent must be obtained when Spectinomycin is used. Complicated gonorrhea should be treated with cephalothin, but care should be exercised as there is a small percentage of cross-reaction with the penicillins.

In the past 18 months, penicillinase-producing *N. gonorrhoeae* have been identified throughout the world. Over 150 isolates of penicillin resistant strains have been found in the United States⁹ and at least one in Nebraska.¹⁰ The mechanism of resistance has been shown to be plasmid-mediated penicillinase production. This enzyme is very similar to the Beta-lactamase produced by ampicillin-resistant *Hemophilus influenzae*. Nucleic acid sequence studies of these two plasmids suggest that the plasmid of the *Neisseria* was probably derived from the *Hemophilus* by conjugation.¹¹ Fortunately, these organisms are still uncommon and their presence has not altered the recommended treatment schedules. However, resistant organisms should be looked for in treatment failures.¹² Spectinomycin is the drug of choice to treat these resistant strains. Unfortunately, a few spectinomycin-resistant cases have already been reported recently in England.

As antibiotic resistant strains have appeared, renewed attention has given to defining the immunologic reaction to gonococcal infection in hopes of developing a

practical vaccine. It is known that patients do not appear to acquire an effective natural immunity to the disease, however, studies in chimpanzees show that a moderate resistance to reinfection develops.¹³ Similarly, studies of the cellular immune system show a response to gonococcal antigens following infection, but of insufficient magnitude to be protective.¹⁴ Many workers currently feel that there may be many, as yet unidentified, serotypes of *N. gonorrhoeae* and this may be the key to the apparent lack of acquired immunity. While a vaccine to prevent gonorrhea is not on the immediate horizon, work continues along this line.¹⁵

A sidelight of the study of the antigenicity of the gonococcus is the development of precise, specific, and sensitive immunologic tests for the detection of gonococcal disease. Serologic tests presently lack both the sensitivity and specificity to be practical and do not compare favorably with culture as a diagnostic technique. Current cultural techniques have a 40%-90% yield depending on the population studied.¹⁶ This is in comparison to fluorescent antibody detection of the organism in the specimen. Unfortunately, fluorescent microscopy is too cumbersome and costly for routine use. A slide-agglutination technique has recently been developed and *in vitro* studies have shown it to

be as sensitive and specific as the immunofluorescent methods.¹⁷ The agglutination technique, should clinical studies prove its effectiveness, may allow the rapid diagnosis from the clinical specimen. This is particularly important in females and in the diagnosis of rectal and pharyngeal disease which presently requires culture of the organism. Also, the test could be easily performed in a small laboratory without expensive equipment.

Equally important as the appropriate recognition and diagnosis of the disease is the recognition that gonococcal infections in children should alert the physician to the potential of sexual abuse of the child, either incestuous or by others outside the immediate family.⁸ However, transmission of gonorrhea among children has been noted without apparent overt sexual contact, as in the instance of multiple siblings sleeping in the same bed, etc. Similarly, a transmission of gonorrhea from child to child by innocent sexual play among children should be considered before accusations of sexual abuse are made. Primary care physicians should be increasingly alert to the possibility of gonococcal infections in children, both among adolescents as well as in the prepubertal population. The incidence is unlikely to decline in the immediate future, and the

TABLE I
Reported cases of gonorrhea in children and adolescents in Nebraska, 1975 and 1976*

Age	1975			1976		
	Males	Females	Total	Males	Females	Total
0-9 years	1	6	7	1	2	3
10-14 years	3	26	29	12	26	38
15-19 years	<u>365</u>	<u>778</u>	<u>1143</u>	<u>380</u>	<u>728</u>	<u>1108</u>
0-19 years	369	810	1179	393	756	1149

*Data obtained from the Division of Venereal Disease Control, State Department of Health, Lincoln, Nebraska.

TABLE II
Reported cases of gonorrhea in children and adolescents, Douglas County, 1975 and 1976*

Age	1975			1976		
	Males	Females	Total	Males	Females	Total
0-9 years	1	5	6	1	2	3
10-14 years	2	24	26	10	21	31
15-19 years	<u>226</u>	<u>480</u>	<u>706</u>	<u>221</u>	<u>464</u>	<u>685</u>
0-19 years	229	509	738	232	487	719

*Data obtained from Venereal Disease Control Office, Douglas County Health Department.

potential for the development of life-threatening complications and/or permanent sterility may be averted by prompt recognition of the mildly symptomatic or asymptomatic child with gonorrhea.

SUMMARY

Gonorrhea is now the most common reportable communicable disease in the United States. In Nebraska, 1,179 cases of gonorrhea were reported in children and youth ages 0-19 in 1975 and 1,149 cases in 1976. During 1975-76, ten of the cases reported were in children *less than* ten years old. Five representative pediatric cases seen at St. Joseph Hospital and Creighton University Health Center are presented, including a case of gonococcal arthritis-dermatitis syndrome and a severe case of gonococcal proctitis.

Current therapeutic recommendations for gonococcal infections in children and adolescents are presented. The development of

penicillin-resistant strains of *N. gonorrhea*, including one case reported in Nebraska, may alter present therapeutic recommendations, although at this time, spectinomycin is not approved by the FDA for use in children. It is essential that physicians be aware of the high incidence of asymptomatic and symptomatic gonococcal infections in children and adolescents and obtain appropriate diagnostic studies to assure prompt diagnosis and correct therapy in the pediatric patient with gonorrhea.

The authors wish to thank the staffs of the Venereal Disease Control Divisions of Omaha-Douglas County and Nebraska State Health Departments for providing the data included in Tables I and II. A copy of the bibliography may be obtained from the authors.

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Catheter Removal of Retained Common Bile Duct Calculi

POSTOPERATIVE T-tube cholangiography has been used for years to discover or rule out retained calculi in the common bile duct. The cholangiogram is very reassuring when normal. If, however, the postoperative cholangiogram demonstrates retained stones in the bile ducts, it is very disconcerting to both the patient and the surgeon. Repeat operation is often more difficult than the original gall bladder surgery and reoperation has a greater morbidity and higher mortality. Some patients in poor general health may not tolerate another general anesthetic or major surgical procedure.

This paper describes an alternative to reoperation for the retained common duct stone, provided a T-tube has been left in place to allow access to the bile ducts. The calculus or calculi can often be removed with a catheter and stone basket. Little or no sedation is required. The author has en-

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countered seven such patients in the last four years and in each case the stone or stones were successfully removed without complication. The medical literature reports infrequent minor complications such as fever, pain, and pancreatitis after stone extractions from bile ducts. Most of these patients recovered uneventfully after several days of antibiotic therapy. There has been one death reported in the world literature from this procedure.¹

The procedure is done in the radiology department under fluoroscopic observation by one skilled in catheter manipulation. The



FIGURE 1

[From above down.] Steel compressible stone basket. Curved teflon catheter. Straight teflon Catheter. Flexible guide wire. 5 cm ruler for scale.

procedure can be done on either an inpatient or outpatient basis. Six weeks should be allowed postoperatively for a fibrous tract to form about the T-tube. After a four-hour fast the patient is brought to the x-ray department and preliminary T-tube cholangiogram is performed to confirm the presence

and position of the suspected stone or stones. The T-tube area is cleaned and the T-tube removed. The simplest method involves entering the T-tube tract with a flexible angiographic guide wire which is passed into the common bile duct under fluoroscopic guidance. This is followed with a 6 French

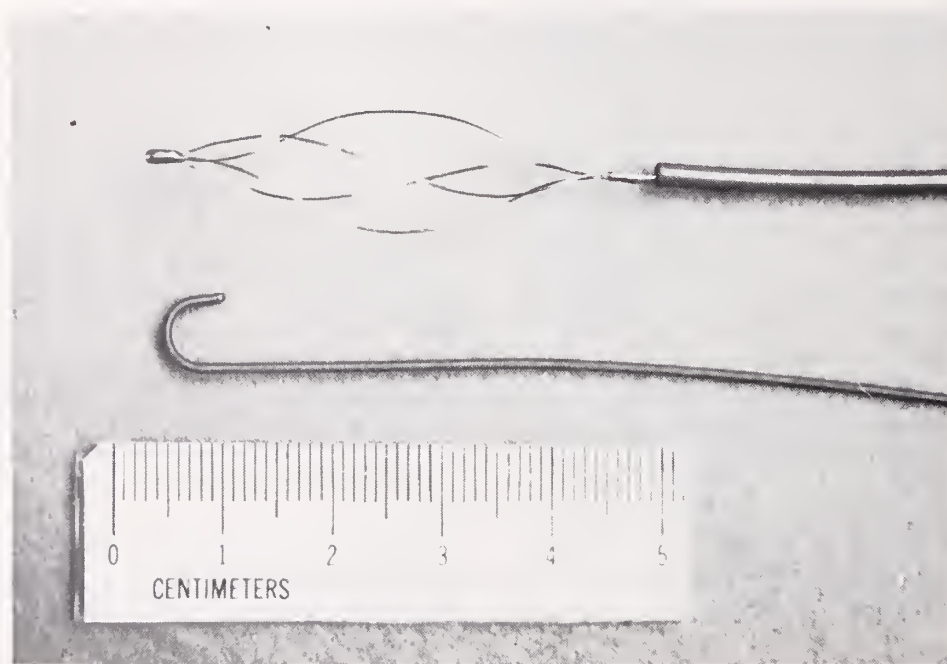


FIGURE 2

Closeup photograph of stone basket and tip of flexible guide wire.

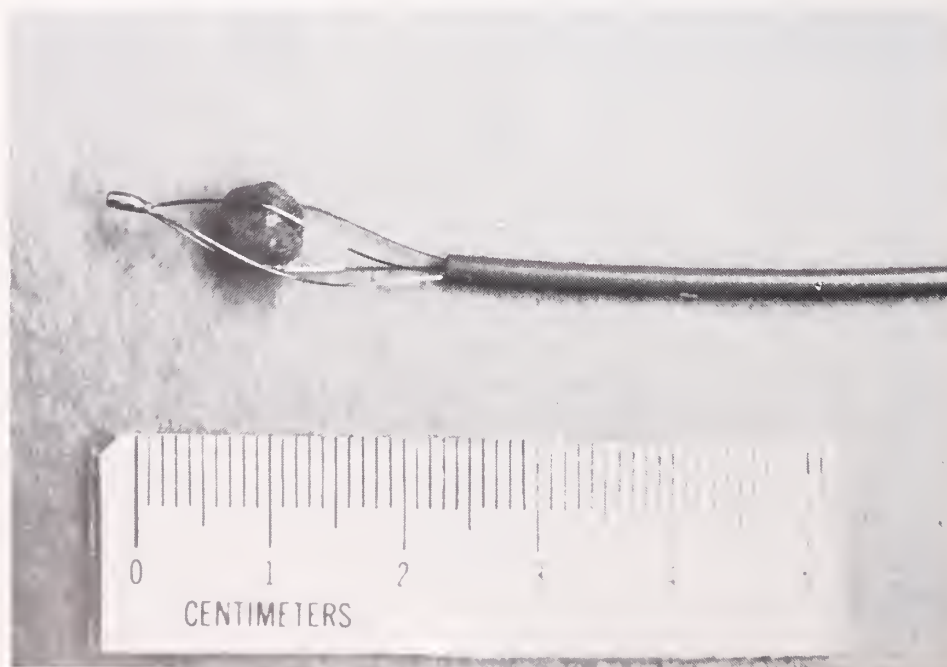


FIGURE 3

Stone basket with calculus snared within it.

teflon catheter. Using the flexible wire guide as a leader, the catheter is positioned distal to the stone. The guide wire is removed. A compressible steel stone basket is passed through the catheter but not beyond the tip of the catheter. In this regard it is important

to note that neither the catheter nor the stone basket should be advanced without the guide wire, as their rigidity significantly increases the risk of perforating the duct. The catheter is then withdrawn to allow the basket to expand and snare the stone (Fig. 1,



FIGURE 4-A
Case 1 — One large stone plus one small stone in the distal common bile duct.



FIGURE 4-B
Case 1 — The larger stone snared in the stone basket and partially removed.



FIGURE 4-C
Case 1 — Post-extraction cholangiogram showing no residual stones.



FIGURE 5-A
Case 2 — Showing three 5mm calculi in the common bile duct.



FIGURE 5-B
Case 2 — With stones being snared by stone basket.



FIGURE 5-C
Case 2 — Final cholangiogram showing no residual stones.

2, 3). The catheter, stone basket, and stone are then withdrawn through the T-tube tract (Fig. 4, 5, 6). If multiple calculi are present, the procedure is repeated. It is not always necessary that the stone or stones be completely removed. On occasion the stone can be pushed through the ampulla of Vater into the duodenum or the stone can be crushed and the fragments pass uneventfully. At the termination of the procedure, a whistle-tip rubber catheter is passed into the common bile duct through the T-tube tract and sutured in place, in order to maintain the tract which would otherwise spontaneously close in 24-48 hours. A repeat cholangiogram is done in a few days through the rubber tube. If further residual stones are found to be present, the extraction procedure is repeated until all stones are removed. When the cholangiogram is negative, the rubber tube is removed and the tract allowed to close. Two of our seven

patients required repeat extractions (eg. Fig. 6A-C).

During recent years several techniques have been developed. In 1969 Lagrave et al² first described the use of a ureteral stone basket in the biliary tract. Burhenne^{3,4} prefers a technique using a steerable catheter. The method of Bean⁵ seems simplest and works best for this author. The extraction procedure is more easily performed if the surgeon has used a 16 French or greater diameter T-tube, if the T-tube tract was kept relatively straight, and the cutaneous exit point of the T-tube was kept somewhat lateral rather than directly anterior.

In summary, there is an alternative to repeat major surgery for the retained common bile duct stone discovered on post-operative T-tube cholangiography.



FIGURE 6-A

Case 3 — T-tube cholangiogram showing at least five large stones in the bile duct.



FIGURE 6-B

Case 3 — Lateral cholangiogram showing some stones removed but some remaining in a cystic duct remnant.



FIGURE 6-C

Case 3 — Final cholangiogram showing common bile duct and cystic remnant free of calculi.

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Rocky Mountain Spotted Fever Presenting as a Generalized Seizure and Acute Hallucinosi

ABSTRACT

An unusual case of Rocky Mountain spotted fever is presented, the initial manifestations of which were a generalized motor seizure and an acute hallucinosis. Subsequently the clinical course, laboratory diagnosis, and pathophysiology of this disorder are reviewed. Concluding remarks are directed toward the residual neurologic deficits occasionally seen following rickettsial infection.

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apparently intoxicated and unable to find his way back to their campsite.

INTRODUCTION

ROCKY Mountain spotted fever is usually considered to have a characteristic clinical course and geographic distribution. The present case report is unusual for two reasons. First, the patient's illness was contracted in a non-endemic region of the country. Secondly, the presenting symptoms of a generalized seizure and acute hallucinosis are atypical in adults with this disorder. Indeed, neurologic manifestations dominated the early part of the patient's clinical course. This prompted the following literature review concerning central nervous system involvement in Rocky Mountain spotted fever. General autopsy and neuropathologic studies in the present case further illustrate the nature and extent of the rickettsial encephalitis produced in this disorder.

CASE PRESENTATION

The patient, a 42 year old white male, and his wife began a two week camping trip on approximately 6-30-76. They visited various campsites ranging from Hastings, Nebraska eastward to the Missouri river. There was no history of tick exposure. The patient had however, been bothered by multiple chigger and mosquito bites while camping. There was an episode early in their vacation, close to Hastings, in which the patient's wife found him collapsed in a weeded area. He was

The patient's illness began approximately 7-12-76. He complained of feeling feverish and having chills. These symptoms were associated with a vague feeling of malaise, a mild bitemporal headache, and generalized myalgia. He noted a dry nonproductive cough. There were no gastrointestinal or genitourinary complaints. The symptoms were mild at the time and the patient continued camping without significant change in his daily activities.

On day three of the patient's illness at 3:00 A.M. he complained to his wife of seeing lights swirling around in the sky. Shortly thereafter his arms began to shake, and he fell to the ground unconscious. While on the ground there was tonic-clonic activity of both upper and lower extremities lasting approximately one minute. There was no cry. He did not bite his tongue, nor was there fecal or urinary incontinence. A postictal period of confusion ensued lasting 15 to 30 minutes. The patient denied any previous seizure activity. There was no family history of epilepsy.

Past medical history included the diagnosis of adult onset diabetes mellitus treated with 1 gm Orinase daily. He was hospitalized in 1970 for what appears to have been acute alcoholic gastritis. The patient's alcoholic history, although implied, was difficult to document. Both he and his wife were reluctant to discuss this subject. He would

admit to drinking only 3 beers per day. His wife, however, described him as a heavy drinker. The alcohol intake continued, but at a decreased rate following the onset of the present illness.

On the third day of the patient's illness, 7-14-76, he was admitted to the Omaha Veterans Administration Hospital for evaluation of his febrile state and single generalized seizure. He appeared ill at the time of admission. Blood pressure was 120/70, pulse 96 and regular, respirations 26, temperature 101.3°F. Positive physical findings included conjunctival erythema, situs inversus, and hepatomegaly with the liver being percussed to be 17 cm overall in the midclavicular line. Examination of the skin showed scattered excoriated erythematous papular lesions over the legs and buttocks. These were thought due to insect bites. No ticks were found. There was no lymphadenopathy. Neurologic examination at the time of admission showed a normal mental status. The cranial nerves were intact except for a mild left internal strabismus. Muscle strength testing was normal. Cerebellar functions were normal in the upper extremities. There was however mild unsteadiness on performance of the tandem gait maneuver. Reflex examination showed normal and symmetrical responses bilaterally. There were no pathologic reflexes. Sensory testing was normal. Station and gait were likewise normal.

The clinical impression at the time of admission was that the patient was suffering from chronic alcoholism with mild alcoholic hepatitis and alcohol withdrawal induced seizure activity.

On the fourth day of illness he began to show increasing disorientation and confusion. The confusion progressed to active visual hallucinations but was unassociated with agitation or combativeness. His daily temperature maximum varied from 102 to 104°F. Bilirubin at this time was 6.4 mgm% total and 4.0 mgm% direct, SGOT was 384 IU (normal 8 to 30), and venous ammonia 190 mgm% (normal 0 to 50). Hemoglobin was 15 gm%, white blood cell count $5.6 \times 10^3/\text{mm}^3$ with 41% polys and 42% bands. The platelet count, prothrombin time, and partial thromboplastin time were all normal. Repeated

chest x-rays showed changes compatible with old granulomatous disease, but no active infiltrates. Blood, urine, and cerebrospinal fluid cultures were sterile. The spinal fluid pressure was measured at 95 mm CSF. No cells were seen. The CSF glucose was 131 mgm%, and the protein was 30 mgm%. An EEG obtained 7-14-76 was abnormal, showing the predominant rhythm to be moderately low voltage theta, with some delta activity randomly distributed. There were no spikes, paroxysmal bursts, or asymmetries seen.

By the fifth day of illness the patient would respond to verbal commands but showed little spontaneous activity and drifted back to sleep if not stimulated. Increasing pulmonary congestion and progressively deteriorating liver function tests were noted. At this time a macular, purpuric nonpapular rash developed, beginning over the extremities involving the palms and soles. It later extended onto the trunk. Serologic studies showed negative *Proteus* OX-19, OX-2, and OX-K titers. The diagnosis of Rocky Mountain spotted fever was entertained at this point but was discarded. The patient's alcoholic history, evidence of hepatomegaly with hepatic dysfunction, single generalized withdrawal seizure and delirious state were all taken as confirmation of the admission diagnosis.

On the sixth day of illness the patient's pulmonary congestion increased. Sputum gram stain showed many polymorphonuclear cells but cultures identified no specific pathogen. Oxygen therapy and parenteral penicillin were given empirically for what was believed to be bronchopneumonia complicating his hepatic encephalopathy.

By the eighth day of illness the patient was moribund. His mental status, respiratory insufficiency, and liver function tests had all continued to deteriorate. A repeat spinal tap was performed showing 10 polymorphonuclear white cells per mm^3 , glucose of 200 mgm%, and protein content of 111 mgm%. Hypotension, a central venous pressure of 2 cm H₂O, peripheral edema, thrombocytopenia, and hypofibrinogenemia were all taken as evidence of peripheral vascular collapse and disseminated intravascular coagulation. Chloramphenicol was added to the antibiotic regimen at this time. The patient sustained a

cardiopulmonary arrest later on the eighth day of his illness, was temporarily resuscitated, and died 28 hours thereafter. Serum obtained on the ninth day of the patient's illness returned from the laboratory post-mortem showing agglutination of the previously negative *Proteus* OX-19 test at 1:80 dilution. Postmortem serologic tests were performed by the C.D.C. on serum specimens from the fifth febrile day and 4 hours before death. The results from the earlier specimen were negative. The complement fixation titer of 1:16 and the indirect fluorescent antibody titer of 1:128 rendered the terminal specimen diagnostic for Rocky Mountain spotted fever.

Autopsy Findings

The general autopsy demonstrated a diffuse vasculitis affecting small arterioles and capillaries in the lungs, heart, skeletal muscle and skin. There was a super-imposed bacterial pneumonitis which grew *E. coli* and *Enterobacter aerogenes* when lung aspirates were cultured post-mortem. Changes of early Laennec's cirrhosis were noted in the liver. The pancreas showed changes consistent with chronic fibrotic pancreatitis.

External examination of the brain at the time of autopsy showed no gross abnormalities. Cut sections of the fixed brain, however, demonstrated a focal area of softening over the right parietal region measuring 2.5 cm in diameter. Two small 1.5 mm petechial hemorrhages were noted on the floor of the fourth ventricle. Microscopic examination of the brain revealed that the ischemic infarction in the right parietal region resulted from severe focal vasculitis with thrombosis of many arterioles. Scattered arterioles and capillaries throughout the cerebral white matter showed endothelial proliferation and perivascular cuffing by polymorphonuclear leukocytes. These vascular changes were similar to those noted in other organs as mentioned above. Giemsa and Gimenez stains revealed small oval rickettsial organisms within the nuclei and cytoplasm of infected endothelial cells in sections of brain and heart. Direct immunofluorescent stains characterized the organisms as *R. rickettsii*.

Discussion

Rocky Mountain spotted fever is rare in Nebraska. The hospital records at both the University of Nebraska Medical Center and Creighton-St. Joseph Hospital were reviewed for the past 5 years. Not one confirmed case of Rocky Mountain spotted fever could be found out of some 148,625 total admissions. The Nebraska Public Health Service lists no cases of this disorder for 1976 and only two in 1975. There was no mention made as to whether these patients contracted their illness locally or while vacationing elsewhere.

This disorder was first reported in Idaho and Montana from which region it derives its name. The greatest incidence of spotted fever, however, is seen in the south Atlantic states of Virginia, North Carolina, Maryland and Georgia. In discussing the epidemiology of this disease Murray describes the occurrence of tick islands.⁸ He quotes earlier work showing for example that 80% of the cases seen in New York state from 1941 to 1970 originated in Suffolk County in central Long Island. Our patient was camping at various locations throughout the eastern part of Nebraska, so it is not possible to determine exactly where he contracted his illness. That the vector was probably a wood tick is implied by the patient's camping activities, his age, and his location in the north-central region of the country. The wood tick is the principal vector in the northern states while the dog tick is more important in the south. No history of tick exposure was obtained from the patient and indeed will not be obtained from approximately 20% of those afflicted. The causative agent *Rickettsia rickettsii* an obligate intracellular pathogen, lives in the tick intestinal epithelial cells and ova.¹ Following inoculation there is an incubation period of from 3 to 12 days. The initial symptomatology is that of a nonspecific febrile illness: generalized malaise, myalgia, headache, anorexia and occasionally vomiting.⁶ Pyrexia begins with the onset of symptoms and is sometimes punctuated by shaking chills. The febrile nature of the illness is prominent.⁴ On approximately the fourth febrile day the characteristic purpuric maculopapular rash develops on the palms and soles. This later spreads to involve the trunk. In the more

severe cases such as the patient reported herein a diffuse vasculitis may develop affecting the heart, lungs, skeletal musculature and brain. The terminal event may be hypovolemic shock, disseminated intravascular coagulation, or superimposed infection.³

The clinical diagnosis of Rocky Mountain spotted fever must be based on the signs and symptoms of the disease. Serologic confirmation by agglutination of *Proteus* OX-19 and specific complement fixation titer is useful in retrospect. Most authors report a 9 to 12 day delay between the onset of illness and elevation of the OX-19 titer. Our patient had negative serologic studies following the eruption of a typical rickettsial rash (fifth febrile day) and died on the ninth febrile day. Obviously, therapy cannot be delayed until diagnostic serologic studies are obtained. Chloramphenicol or tetracycline are the drugs of choice for this disorder.

The case being presented was unusual in that the patient's initial complaint was that of a generalized motor seizure. Small children with Rocky Mountain spotted fever occasionally have convulsions associated with the onset of fever.² These are however not necessarily associated with a poorer prognosis. Seizures are infrequently seen in the adult population and when they do occur they are a grave prognostic sign.^{5,7} Of the 60 adults reported by Miller there were two patients with generalized motor and one with focal motor seizures.⁷ The two patients with generalized seizures were moribund, comatose at the time their seizure activity began. They expired within 48 hours. Our patient experienced only one generalized motor seizure. This occurred prior to admission and except for the ictal and postictal manifestations was unassociated with any clouding of consciousness. Changes in sensorium were not present until approximately the second hospital day. At this time he developed an acute confusional state with visual hallucinations. This gradually gave way to deepening coma over the subsequent 4 days. The CSF pleocytosis seen terminally plus the autopsy findings confirm the presence of an acute encephalitis. The hepatic insufficiency resulting from the systemic vasculitis and underlying Laennec's cirrhosis added a component

of metabolic encephalopathy. It is impossible to state whether our patient's initial seizure was due to the developing encephalitis or alcohol withdrawal. The etiology of the delirious state and subsequent coma is likewise difficult to determine. Either the encephalitis or concurrent toxic-metabolic encephalopathy would provide an adequate explanation.

The altered mentation seen in our patient is not unexpected and can indeed be found in approximately 60% of patients with Rocky Mountain spotted fever. Miller reported a series of 60 patients, 36 of whom had mental changes ranging from lethargy to coma.⁷ The severity of the change was directly proportional to the duration of the illness. Irritability or mild lethargy was noted in 14 patients. Disorientation, memory impairment or confusion was present in 7 cases, delusions or hallucinations in 7, and stupor or coma in 8. In addition to the diffuse changes in sensorium he records a number of focal neurologic abnormalities reflecting cerebral, cerebellar, and brainstem lesions. Five of Miller's 60 cases had focal neurologic deficits, 5 had nonfocal neurologic signs, and 31 had alterations limited to various degrees of impaired mentation. These statistics are similar to those presented by Harrell and Bell. Careful neurologic examination will also often reveal ophthalmoscopic abnormalities ranging from retinal edema to retinal hemorrhages and vascular occlusion.⁹

Central nervous system involvement in Rocky Mountain spotted fever reflects only one aspect of the diffuse vasculitis produced by this disorder. The brain, retinal vessels, lungs, heart, and kidney can all be affected. There is invasion of the endothelial cells by the rickettsial organisms. These organisms replicate within the nucleus and to a lesser extent within the cytoplasm of the host cells. The infected endothelial cells begin to proliferate, swell and degenerate producing occlusion of the capillary-arteriolar lumen.⁵ Within the brain these changes lead to the microinfarctions and subsequent glial nodules seen in the various rickettsial diseases.⁵ Meningeal abnormalities characterized by the presence of blood pigments and scant phagocytic cell infiltrations are often noted. In an autopsy series consisting of 6 patients re-

ported by Harrell, all patients had microscopic CNS changes.⁵ An autopsy series by Miller consisting of 9 brains showed only one case without definable microscopic lesions.⁷ This was a patient who died on the 7th day of his illness. Miller found vascular lesions scattered throughout the brainstem grey matter in 5 of his 9 cases. Specific areas involved included the olivary nuclei, periaqueductal grey area, and the lateral medullary reticular nuclei. The remaining patients in his series showed scattered lesions affecting the cerebrum, cerebellum, and subependymal layers of the fourth ventricle. A slight lymphocytic infiltrate of the pia-arachnoid was noted in 5 patients. Bell refers to the presence of focal CNS lesions due to intracerebral bleeding rather than the more accepted process of infarction and gliosis.² He quotes previous work showing a temporal association between the thrombocytopenia which is part of Rocky Mountain spotted fever, and intracerebral hemorrhage. His two patients suffered the sudden onset of focal deficits and simultaneous subarachnoid hemorrhage.

The neuropathological findings seen in our patient are described in the autopsy protocol above. The subependymal petechial hemorrhages in the floor of the fourth ventricle, and the microscopic evidence of vasculitis are what one would expect. The large area of focal edema in the right parietal region is unusual. This represents an area of acute cerebral infarction precipitated by the underlying vasculitis. The cerebral vessels comprising the circle of Willis were thin and translucent without gross evidence of atherosclerotic involvement. There was no apparent site for embolus formation seen either in the heart or aorta. The carotid vessels were patent to perfusion.

The long-term neurologic sequelae in Rocky Mountain spotted fever were evaluated by Harrell in 1953. He found neurologic abnormalities in 6 of 37 patients examined one to eight years after the acute illness.⁵ The neurologic findings included impaired fine movements, hypotonia, hyperreflexia, unequal reflexes, clonus, Babinski sign, gait disturbance, disturbed behavior, and mental retardation. Follow-up EEGs in the 37 patients showed 12 to be abnormal.

Focal spikes and/or spike and slow waves were present in 8 cases. Focal slowing was seen in one case, generalized beta in two cases and "a slow basic rhythm" in one case. Impaired intellectual functioning has also been described as a late sequela in RMSF. Wright studied 12 patients with a battery of 3 different psychological tests.¹⁰ He used age, race, and socio-economic matched controls and found that the spotted fever patients had several areas of significant deficiency. The patient population was significantly below the control group on the Wechsler intelligence scale for children (WICS) verbal and performance tests. The full scale WICS scores were also significantly lower for the patients than for controls. Frostig eye-motor test scores were significantly lower in the spotted-fever patients while the Bender-Gestalt testing showed no difference.

SUMMARY

An unusual case of Rocky Mountain spotted fever was presented, the initial manifestations of which were a generalized motor seizure and an acute hallucinosis. Subsequently the clinical course, laboratory diagnosis and pathophysiology of this disorder were reviewed. Concluding remarks were directed toward the residual neurologic deficits occasionally seen following rickettsial infection.

Acknowledgment:

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Superficial Esophageal Carcinoma Diagnosed Solely by Endoscopy

INTRODUCTION

THIS paper reports a patient with superficial carcinoma of the esophagus diagnosed by endoscopy in the absence of roentgenographic findings. Early diagnosis of esophageal malignancy is rare. Early diagnosis by endoscopy and surgical resection offers significant potential for long term survival in esophageal malignancy.

CASE REPORT

A 76 year old female was admitted to Bishop Clarkson Memorial Hospital May 19, 1976, to evaluate a twelve month history of progressive dysphagia without weight loss. Two previous barium examinations with x-ray and fluoroscopy three to six months prior to admission, were negative even when reviewed retrospectively. There was no history of tobacco or alcohol use and nutritional history failed to reveal any idiosyncrasies in diet or food preparation.

Physical examination was unremarkable except that she appeared younger than her age. Laboratory and roentgenographic data were unremarkable, however, carcinoembryonic antigen (CAE) level was greater than 8 ng/ml (normal less than 5 ng/ml). Specifically, fluoroscopy of the esophagus with barium contrast revealed no intrinsic or extrinsic lesions. Esophagoduodenoscopy was performed. Thirty centimeters from the incisors, coarse, friable, nodular mucosa was encountered and biopsied. In addition, the endoscopist encountered gastritis and a normal duodenum. Biopsy revealed a grade II squamous cell carcinoma.

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The patient underwent a right thoractomy, resection of the thoracic esophagus, esophagogastrostomy, and Heineke Mikulicz pyloroplasty. The lesion was a grayish mucosal thickening one by two cm located in the middle third of the esophagus. Histologic sections revealed superficially invasive, moderately well differentiated squamous cell carcinoma. There was no gross evidence of metastatic disease at operation and biopsied nodes were tumor free. Postoperative recovery was uneventful. The patient has had problems with midsternal fullness following meals. Endoscopy at two, five months, and one year postoperatively revealed no evidence of recurrence. The CEA level dropped to normal one week postoperatively, and was normal at five months and one year. She remains in excellent health 16 months postoperatively and we anticipate that she should remain so.

DISCUSSION

Progressive problems with swallowing in older patients, even in the absence of roentgenographic changes, merit further evaluation including endoscopy. From an epidemiologic perspective, this patient was unique. The prognosis for this patient, unlike

the majority of esophageal carcinomas, is excellent.

Carcinoma of the esophagus is responsible for two percent of cancer deaths in the United States. Esophageal malignancy is intriguing because the incidence and male to female ratio vary widely throughout the world. These differences illuminate various etiological factors for the disease. In the United States esophageal cancer is a disease of aged, tobacco, and alcohol using males with an incidence of 10 (per 100,000) males and 3:1 male to female ratio. This contrasts to Iran with an incidence of 110 for males and 184 for females. Japan has an incidence of 46.3 and Finland, Sweden, and South African Bantu have equal rates among men and women.^{1,2} Several risk factors have clearly been identified. The risk of esophageal malignancy is increased two to six times by tobacco use. Alcohol, even when used to excess, increases the risk only in the presence of tobacco consumption. The rate of esophageal cancer in France is increased in regions where alcohol consumption is high. High incidence among the Bantu is related to the type of alcohol consumed. Poor nutrition and betel chewing are implicated in the high incidence of the disease in Ceylon and India.³ In northern China, dietary consumption of the fungus *Geotrichum candidum* has been implicated as a possible etiological agent. Interestingly, the chickens of this region share a high rate of esophageal neoplasm.⁴ Lye stricture, achalasia, hiatal hernia, and Plummer-Vinson syndrome (dysphagia, glossitis, and anemia) are associated with esophageal malignancy. Less well understood are the effects of poor nutrition, vitamin deficiency, anemia, poor dental hygiene, dentures, and previous gastric surgery. Zinc, radiation, nitrosamines, other metals and organic compounds may be specific esophageal carcinogens.² Although there is little evidence for familial predisposition, a syndrome including hyperkeratotic nodules over the knuckles (tylosis articularis), oral leukoplakia, and early onset of esophageal carcinoma has been described in several families.⁵ Our patient is unique in that she was free of all known risk factors.

The patient's lesion was located in the middle third of the esophagus. Carcinoma

occurs most often in the lower third of the esophagus (43%), then middle third (37%) and upper third (20%) respectively. Generally the clinical presentation of esophageal cancer is an early mild difficulty with swallowing high in the esophagus. Other causes of dysphagia including functional dysphagia, Plummer-Vinson syndrome, cricopharyngeal sphincter spasm, achalasia, diffuse esophageal spasm, hiatal hernia, and scleroderma may also present this way. This early dysphagia is thought to be due to disruption of peristalsis. This may be due to the bulbous effect of the tumor. The tumor may disrupt peristalsis via Auerbach's and Meissner's plexus or by involvement of the vagi or esophageal sympathetics. Later, obstruction occurs, the patient changes his diet to soft foods, begins losing weight, and generally will seek medical care.² Seventy-five percent of the patients with esophageal malignancy will not survive 12 months beyond diagnosis. Reports of esophageal carcinoma diagnosed before developing polypoid, ulcerative, or infiltrative changes on roentgenograph are rare. Early detection of carcinoma of the esophagus has greatly been aided by the advent of the flexible forward viewing fiberoptic endoscope with biopsy capabilities.⁶ Esophageal lavage with Levin tube and saline for exfoliative cytology enjoys limited usage but has potential as a screening procedure for early lesions. Forty-seven of fifty-one patients with squamous cell carcinoma had positive lavage in a recent series. The incidence of false negatives would be high in small lesions.^{7,8}

It is of interest that the Chinese, who have a high rate of esophageal malignancy in the north, use a net covered balloon for cytologic screening. This had led to the detection of early esophageal lesions and precancerous dysplasia. It is claimed that the resection rate has increased to 80%, and the five year survival to 29%.⁴

The treatment of carcinoma of the esophagus is hindered by strategic location and widespread disease at time of diagnosis. Spread by submucosal and muscular lymphatics often results in recurrence at resected margins. Metastases is to the liver in 32%, and lungs or pleura in 21%.

There is a low incidence of distant metastases by hemotagenous spread but this may be due to short life span. Nodal spread is related to size of the lesion. In lesions less than five cm., 50% have no nodal spread.⁹

Our case is similar to 28 superficial (infiltration limited to the submucosa) squamous cell carcinomas under four cm in diameter, 25 of which were diagnosed by endoscopy, reported from several institutions in Japan. Commonly, the patients presented with retrosternal pain, dysphagia, and/or unusual sensations upon swallowing. All patients underwent resection with 11 of the 28 patients receiving preoperative radiation. Although the period of followup was less than one year for five patients, there was a two year survival of nine patients (29%). All deaths occurred in the first twelve months, and there was one eight year survival.¹⁰

In the Mayo Clinic series of 1,657 patients seen from 1946-1963, the five year survival after resection for 31 middle esophageal lesions without nodal involvement was 41.9%. This contrasts to an overall five year survival of nine percent and in patients undergoing surgical resection, 14.9%.¹¹

Although our patient has had some problems with swallowing postoperatively, there has been no local recurrence of tumor and prognosis for long term survival is excellent. Fiberoptic endoscopy has great potential for early diagnosis of esophageal malignancy

improving chances for surgical therapy and long term survival in this devastating disease. Endoscopy should be included in the workup of all unexplained dysphagia in older patients.

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Down Memory Lane

1. On the business side of his activities, the physician is hedged about and limited by an ancient code of ethics.

2. Skeletal traction or direct bony traction is a procedure which mechanically is sound and effective in maintaining length in fractures of the femur.

3. Tuberculosis in childhood is essentially a lymph gland tuberculosis involving especially the tracheobronchial and the hilum glands.

4. The average physician collects only sixty per cent of what he earns.

5. The best balanced program in many a year featured the annual meeting held at Hastings, May 15-17.

6. The Nebraska Eclectic Medical Society met at Lincoln, May 22 and 23.

7. The ideal skin-graft should secure the shortest possible period of convalescence, the greatest per cent of successful "takes" and the nearest possible approach to the normal appearance of the newly covered area.

8. Antepartum hemorrhage, particularly in the last trimester of pregnancy, is one of the major disasters of pregnancy.

9. The doctor has spoiled the public.

10. If the modern conception of the desiderata in school ventilation is correct, the practice of always supplying 30 cubic feet of air (fresh or recirculated) for each child per minute appears not only unnecessary but wasteful.

Nebraska State Medical Journal
June, 1928.

President's Page

THOUGHTS ABOUT THE PRESIDENCY OF THE NEBRASKA MEDICAL ASSOCIATION

What motivates a busy physician to become President of the N.M.A.?

One reason might be an ego trip. This can be summarily dismissed because the preparation for the task is too long and the job is too arduous and time consuming to give this credence. Additionally, it was General Stilwell who said "The higher a monkey climbs, the more of his behind you can see."

Medicine has been very good to my family. My grandfather began practicing medicine in Aurora ninety-three years ago. My interest in organized medicine was aroused in 1951 when my father became President of the N.M.A. We have had the privilege of knowing and respecting some of the movers and shakers of medicine. Can this job be a partial repayment of a debt owed to medicine? You bet it can!!!

The preparation for this position has been long — eight plus years in the House of Delegates and eight years on the Board of Councilors. It has for the most part been pleasant, except for an occasional "second most painful thing in my life." Further intensive preparation has been obtained this past year at the elbow of a most competent leader, Arnold Lempka. Your dedicated and knowledgeable staff have similarly contributed much to this preparation.



Various people have asked me if I was ready for this job. The only possible true answer is NO. It is absolutely horrifying to see how easily the bureaucrats can nearly totally obstruct our pathways, however, I assure you that with your continued help, guidance and support we shall meet the challenges of these various "opportunities," and shall not fail for lack of trying.

Houtz G. Steenburg, M.D.



The Auxiliary

**Nebraska Medical Association Auxiliary
Annual State Convention Meeting
April 30 - May 3, 1978
Report: Resolutions Committee**

WHEREAS, We consider it fitting and proper to express our thanks to all who have contributed to the success of the convention and the accomplishments of our past year's work; therefore be it

RESOLVED, That we, the members of the Nebraska Medical Association Auxiliary, extend our grateful thanks and appreciation to the officers and other members of the Executive Board of our organization, who have so ably carried on the business necessary for the proper functioning of the Auxiliary; and be it further

RESOLVED, That our thanks and appreciation go to the members of the Auxiliary to the Lancaster County Medical Association, hostess to this Fifty-third Annual Meeting; for the welcome hospitality extended to all of us; and be it further

RESOLVED, That we express particular gratitude to Mrs. Stephen Carveth and Mrs. Joseph Rogers, Convention Chairmen, and to their committee chairmen for their work and thoughtfulness in planning for our convenience and entertainment, and be it further

RESOLVED, That the Nebraska Medical Association be advised that we appreciate their leadership and assistance, and, for including us in the "Symposium on Circadian Rhythms," that in particular Dr. Arnold W. Lempka, President of the Nebraska Medical Association, and the Advisory Committee,

Dr. Guy M. Matson, Chairman, be informed of our gratefulness for their help and guidance throughout the year, and be it further

RESOLVED, That Dr. Frank Cole, Editor of the Nebraska Medical Journal, Mrs. Warren Bosley, Editor of the NEWSLETTER, Blue Cross-Blue Shield for their continued interest and support of our NEWSLETTER, Mr. Kenneth Neff, Executive Secretary of the Nebraska Medical Association, Mr. William Schellpeper, Assistant Executive Secretary, and the office assistants for their help in preparing materials and mailing the NEWSLETTER, be advised of our sincere thanks for the efficient way they have handled our Auxiliary news, and for their ready assistance whenever we asked for it, and be it further

RESOLVED, That we express our thanks to the management of the Lincoln Hilton, Hovland-Swanson Co., Dorsey Laboratories, Mrs. M. J. Epp and Mrs. Stephen Carveth, for their assistance in arranging the "Home Tour," the Sun Newspaper and the Lincoln Journal and Star, and be it further

RESOLVED, That we pledge our loyalty and devotion to the Nebraska Medical Association Auxiliary; that we continue to be faithful in supporting its activities; promoting its projects and protecting its reputation and high ideals, and be it finally

RESOLVED, That these resolutions be published in the NEBRASKA MEDICAL JOURNAL.

Respectfully submitted
Mrs. Frank H. Tanner
Chairman



Every effort is made to give proper recognition to contributors to the Health Galleries. If an error has been made, please notify Helen L. Hayes, Chairperson, Auxiliary Health Gallery Committee, 11711 Van Dorn, Walton, Nebraska 68461.

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*House of Delegate action October 1976, recommended that each physician donate \$200.00 over a three year period.

67% of the \$150,000.00 has been raised through contributions made by physicians listed in the Nebraska Medical Journal. All monies raised will be used for the development of the exhibits in the galleries.

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Our Medical Schools

Test for chhalasia.

Dr. Jon A. Vanderhoof, Assistant Professor of pediatrics at University of Nebraska Medical Center, has modified a commonly-used diagnostic system to detect chhalasia in babies, a disorder marked by severe vomiting and subsequent malnutrition as the result of a weak lower esophageal sphincter, which normally keeps the stomach contents from being expelled.

A small tube is placed down the infant's esophagus and electronically measures the pressure of contraction at various levels as the child swallows. If the pressure is abnormally low in the area of the esophageal sphincter, it is usually a sign that the valve is lax and causing the vomiting associated with chhalasia.

With funding from the Swanson Center for Nutrition, Dr. Vanderhoof adapted his technique from an almost identical diagnostic system, which is used on adults with similar gastrointestinal problems but incorporates the use of four tubes.

Dr. Vanderhoof has found that by using a single tube which is relative to the size of the patient, good diagnostic results can be obtained. Of the approximately 50 infants on whom he has used the modified technique, he has had almost a 100 per cent accuracy rate in detecting chhalasia.

To verify his results and gain further information on each patient, he follows the technique with another procedure to determine the child's degree of vomiting. By filling the child's stomach with acid and placing a pH tester in the esophagus, the intensity with which the fluid is expelled can be monitored.

These two techniques can also be used to detect one of chhalasia's common complications, recurrent pneumonia, which is brought about by the aspiration of expelled fluid.

Such complications can be avoided, however, if the child is properly treated by

keeping him in an upright position even when sleeping and using antacids, which seem to strengthen the esophageal sphincter.

Rural health.

Western Nebraska communities will have the opportunity to hear about the state's rural health problem from the health profession student's point of view.

The University of Nebraska Medical Center's Student Rural Health Task Force is establishing a program in which students will meet with community organizations and schools throughout the state to explain what the Medical Center is doing about the rural health manpower shortage and what the communities can do to help themselves.

According to Mary Kay Bowen, a first-year medical student and task force chairperson, the community visits will serve a variety of purposes including the improvement of communication between UNMC and rural Nebraska, the education of Nebraskans on how rural health care has changed and the increase of interest about health careers among young Nebraskans.

Ms. Bowen said the community meetings will be conducted by four students, one representing each of the Medical Center colleges. They will present a 45-minute program, including a 15-minute slide-tape show, and field questions from the audience.

With the task force in the process of setting up the first meetings, Ms. Bowen said organizations or schools interested in participating in the program can contact her at Conkling Hall, P.O. Box 214, University of Nebraska Medical Center, 42nd and Dewey, Omaha (68105), or call 402-541-7773.

Medical school: 3 years or 4?

Making the transition from a three-year to a four-year medical curriculum is not done by

merely lengthening the educational programs; the University of Nebraska College of Medicine will be coordinating four curricula simultaneously over the next few year.

In addition to continuing the three-year program for students who began in 1976 and 1977, the college will also be managing four-year programs for the July 1978 freshman class, the class beginning in the fall of 1979 and the currently enrolled students who opted for the four-year program.

The college originally changed from a four-year to a three-year program in 1970 to speed up medical education and increase the number of medical graduates, although students could extend their schooling by another year.

While the 1979 entering class will inaugurate the definitive four-year curriculum, which is still being planned, the four-year program for the 1978 freshman class has been designed as a transition to provide

courses for current freshman students who extended, thus avoiding repetition of the classes in the same year.

There are at least 50 extending first-year students who will graduate in 1981, a year which was thought by most college officials to have few graduates because of the two-year lag between the graduation of the last three-year class and the first regular four-year class.

Being caught between the three and four-year classes, however, will not mean a reduction in the caliber of the extending students' education.

With the 1978 freshman class receiving six months of flexible time and the 1979 entering class getting three months, future students will find more time for research, community health care electives, and projects not included in the standard curriculum, while experiencing the same educational areas as found in the three-year plan.

Welcome New Members

William A. Albano, M.D.
Department of Oncology
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601 North 30th
Omaha, Nebraska 68131

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310 West 7th Street
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Ashland, Nebraska 68003

Lloyd Westerbuhr, M.D.
226 West 38th Street
Scottsbluff, Nebraska 69361

Between Cases

WHILE MAKING ROUNDS

Quote Unquote.

The cure for insomnia is lots of sleep.
Anon.

The History.

My left eye isn't right.

To A Patient.

There were a lot of gaps in what they taught us in medical school and you seem to fall into most of them.

W. Stanton: The old familiar booby traps of home.

Words I Can Do Without.

Keeping a low profile, in his own words, sticky wicket, multiple, crepitanace.

The Physical.

However, the musculature of the right thigh are all normal including the left lower extremity.

Arnica, Anyone?

When I was much younger, someone was always getting hit in the comic section of the newspaper, and they would always send out for arnica. Does anybody remember arnica?

Section On Statistics.

20,000 babies with fatal congenital malformations are born in the U.S. each year.

The Admitting Diagnosis And The Time.

September 32: pain in right hip.

Department Of Psychiatry.

Show me a normal man and I'll cure him.
Jung, I think.

O To Be In England.

It is conceivable that he might have got over his injuries, but only as a cabbage.

G. Bellamy: The secret lemonade drinker.
We say vegetable.

Section On Anesthesiology.

Except in the matter of anesthetics, do you think the world any better place than it was when you were young?

Question once put to Eleanor Roosevelt.

The Diagnosis.

Limitation of motion of the left shoulder due to joint.

Heard On TV.

Stock up and save; limit one.

Quote Unquote.

How is it that little children are so intelligent and men so stupid? It must be education that does it.

Alexandre Dumas, fils.

—F.C.

The Letter Box

To the Editor:

I take this opportunity to inform you of the recently elected officers of the Nebraska Chapter of the American College of Radiology for 1978-79.

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Sincerely,
William H. Northwall, M.D.
Secretary-Treasurer

Dear Doctor Cole:

Congratulations! On your Sandoz award...

Your journal is full of medical knowledge and plenty of humorous antidotes to win a prize each month! I always look forward to your journal and hope you continue the good work.

Sincerely,
Miriam Polich
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Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.





In treating certain G.I. disorders...

Enhance your therapeutic expectations
with the triple benefits of

Adjunctive
Librax

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br.

antianxiety/antisecretory/antispasmodic

Librax is unique among G.I. medications
in providing the specific antianxiety action of
LIBRIUM® (chlordiazepoxide HCl) as well as the potent
antisecretory and antispasmodic actions of
QUARZAN® (clidinium Br) for adjunctive therapy
of irritable bowel syndrome* and duodenal ulcer.*

ROCHE

*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE **DYAZIDE®**

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

Warning

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Indications: When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen with thiazides appear and triamterene may appear in breast milk. If nursing is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic electrolyte determinations (particularly sodium) in patients vomiting, on diuretics, or receiving parenteral fluids).

Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions:

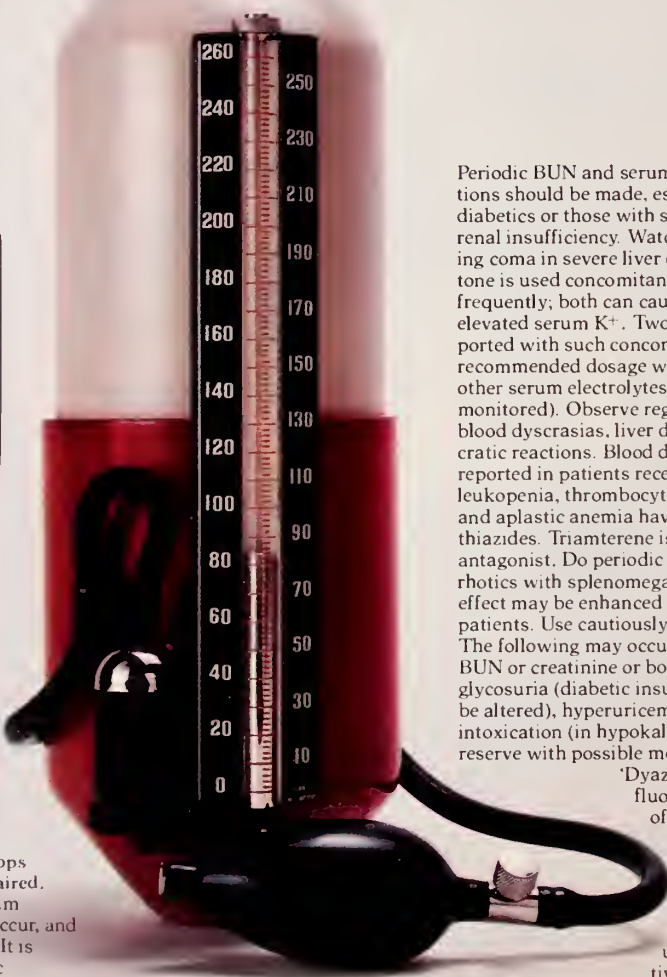
Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

SK&F CO., Carolina, P.R. 00630

SK&F CO.
a SmithKline company

**FOR LONG-TERM CONTROL
OF HYPERTENSION.*
SERUM K⁺ AND BUN SHOULD
BE CHECKED PERIODICALLY.
(SEE WARNINGS SECTION.)**



Coming Meetings

CRIPPLED CHILDREN'S CLINICS —

June 3 — Grand Island, Nebraska
Veterans Home

June 24 — North Platte, Elks Lodge

THE FIRST INTERNATIONAL SYMPOSIUM OF THE INTERNATIONAL COLLEGE OF PEDIATRICS —

June 18-22, 1978, Finlandia Hall, Helsinki, Finland. Plenary Sessions, Symposia, Round-table discussions, Free papers. George D. Maragos, M.D., M.Sc., Associate Professor of Pediatrics, Creighton University Medical School, Omaha, Nebraska, 68108, USA.

AMERICAN MEDICAL ASSOCIATION —

Annual Convention, June 17-22, 1978, St. Louis, Missouri.

NEBRASKA MEDICAL ASSOCIATION —

Fall Session, September 21-23, 1978, Lincoln Hilton Hotel, Lincoln, Nebraska.

OMAHA MID-WEST CLINICAL SOCIETY:

46th Annual Postgraduate Assembly; Omaha Hilton Hotel; October 30, 31 and November 1, 1978. Write to: Lorraine E. Seibel, Executive Secretary, Omaha Mid-West Clinical Society, 540 Medical Arts Building, Omaha, Nebraska 68102.

AMERICAN MEDICAL ASSOCIATION —

Interim Session, House of Delegates, December 2-6, 1978, Palmer House, Chicago, Illinois.

AMERICAN MEDICAL ASSOCIATION —

Winter Scientific Program, December 7-10, 1978, Las Vegas, Nevada.

Medicineews

Our neighbor to the north.

1978 Black Hills Summer Seminar, Holiday Inn of the Northern Black Hills, Spearfish, South Dakota, August 10-12, 1978. Sponsor: South Dakota Chapter AAFP, approved for 15 hours prescribed AAFP and Category 1 AMA credits. Contact: L. H. Amundson, M.D., Secretary SDAFP, 3001 South Holly Avenue, Sioux Falls, South Dakota 57105.

Black Hills Winter Ski Seminar, Holiday Inn of the Northern Black Hills, Spearfish, South Dakota, February 1-3, 1979. Sponsor: South Dakota Chapter AAFP, Category 1 AMA and AAFP prescribed credits. Contact: L. H. Amundson, M.D., Secretary SDAFP, 3001 South Holly Avenue, Sioux Falls, South Dakota 57105.

Washington Notes

Hospital costs.

In a major national address President Carter urged voluntary restraint of labor and management to curb wage and price increases. Though rejecting mandatory controls for all other segments of the economy he urged passage of his hospital cost containment bill that would place a lid on hospital revenue increases.

The President said that daily hospital costs have jumped from \$15 in 1950 to more than \$288 today. "And physician fees have gone up 75 percent faster than other consumer prices."

In the immediate wake of the President's speech, Health, Education and Welfare Secretary Joseph Califano announced a number of belt-tightening measures, primarily the importance to the Administration of passing hospital revenue cap legislation.

The HEW Secretary said that he expects Congress will approve his plan to cap hospital revenues nine percent a year. He also said that Sens. Edward Kennedy (D-Mass.) and Herman Talmadge (D-Ga.), chairmen of the two Senate health subcommittees, have apparently reached agreement after a long impasse to bring the proposal to the Senate floor this year.

Subsequently, the President met with the chairman of a House health subcommittee, Representative Dan Rostenkowski (D-Ill.), to stress the importance of limiting hospital fees.

Afterward, Mr. Rostenkowski told reporters that Congress has a better chance of approving the hospital cost containment proposal than anything else in President Carter's legislative package.

Congressional leaders, including Robert C. Byrd (D-W.Va.), the Senate majority leader, indicated they would push hospital cost containment as a major bill this session.

The most important regulatory measure in Secretary Califano's belt-tightening list will limit Medicare payment for laboratory tests

and medical equipment "to the lowest price that is widely available for the same quality in a particular community, instead of paying on the basis of average charges or even higher ones."

The initial limit will apply to the 12 most common lab tests and to hospital beds and wheelchairs purchased for Medicare patients. The limits are to be extended to other tests and equipment later.

National health insurance.

Labor leaders and Senator Kennedy are again calling upon the White House with redrafted versions of their brand of national health insurance (NHI) in search of some sort of face-saving compromise. And the President, though his welcome mat is out, is reportedly doing his best to convince labor to draw back a bit from its original insistence on a wide-sweeping plan and go along with an affordable approach that the Congress might buy.

Labor has told the President it is willing to abandon provisions of its Health Security Act under which the federal government would handle all of the financing for NHI, eliminating private health insurance. The current discussions center on how far labor is willing to retreat.

The President and White House staff apparently felt labor must shift its position even more since the Administration is vitally interested in submitting a legislative proposal that "represents a consensus and is saleable and affordable," said one participant.

Drugs.

Vital decision-making authority on drug treatment of patients would be transferred from the practicing physician to bureaucrats in Washington, under legislation before Congress, the AMA has warned.

Testifying on sweeping bills to change the nation's drug laws, the AMA told Sen.

M & M losses.

Waste, fraud, and abuse accounts for more than \$4.5 billion in annual losses in the federal Medicare and Medicaid programs, according to the annual report of the Inspector General's Office at HEW.

The report listed \$2.3 billion to \$2.6 billion losses in Medicaid last year, and \$2.2 billion in Medicare losses as part of an overall total of \$6.3 billion to \$7.3 billion in all HEW programs. Money spent unnecessarily in other programs includes \$669 million for Aid to Families with Dependent Children, \$494 million to \$1.2 billion in Income Security and other Social Security programs, \$88 million for Social Services, \$3.6 million from the Student Financial Aid Program, and \$97 million in Aid for Disadvantaged Children education.

Kennedy's health subcommittee that the Administration bill "improperly crosses the line which should separate the regulation of drugs to assure their safety and efficacy and the regulation of the practice of medicine through the regulation of drugs."

William C. Felch, M.D., Chairman of AMA Council on Legislation, testified that provisions in the measure would allow medical decisions to be made by a government agency. Dr. Felch pointed to provisions allowing HEW to impose dispensing and distributing conditions on drug use; requirements for patient information labeling for nearly all drugs even against physicians' recommendations; and authority for the government to decide such factors as relative efficacy in comparison with other treatment modes, intentional abuse potential and use for nonapproved purposes.

Physicians' Classified

Advertisements in this column are run at a rate of twenty cents per word with a minimum of \$10.00 per insertion. Copy must be received by the fifth of the month preceding date of publication and should not exceed 50 words. Each advertisement will be taken out following its first appearance unless otherwise instructed. Where numbers follow advertisements, replies should be addressed in care of The Nebraska Medical Journal, 1902 First National Bank Building, Lincoln, Nebraska 68508.

GENERAL SURGEON NEEDED. Excellent opportunity in west central Iowa community of 10,000. New hospital, partnership available, good contract. Call Ed Murphy, Carroll Medical Center, Carroll, Iowa 712/792-1500.

FAMILY PRACTITIONER - PREPAID GROUP PRACTICE — Join physicians in Lincoln, Nebraska, establishing a prepaid group practice. Attractive salary based on training and experience. Family Practice board certified or eligible preferred. No investment necessary. Practice in newly designed ambulatory care facility in groups of four physicians working with physicians assistants and mental health professionals. On-site laboratory, x-ray, physical therapy, optometry, and pharmacy. All permanent staff salaried. No insurance forms, personnel problems or administrative paperwork, and all records typed on problem-oriented format. Liberal fringe benefits including malpractice insurance, retirement, and continuing medical education. Regular hours with rotating on-call duty. Interested candidates may submit their c.v. to: Wm. B. Mitchell, M.D., M.P.H., Medical Director, Health Central, 615 Anderson Building, Lincoln, NE 68508.

FAMILY PHYSICIAN NEEDED — 30 minutes S.E. of Omaha. G.P. with large practice moved to specialize. Office space available. Nearby hospital will offer financial incentive and staff will refer all local patients. Active established community with new \$35,000 ambulance with Life-Pak 5 and reliable hospital-trained crew. Contact D. Langone, D.D.S., Box 475, Malvern, Iowa 51551 or (712) 624-8634 (collect).

STAFF PHYSICIAN — General practitioner to perform general examination, care, and treatment of patients or staff at state psychiatric hospital. Surgery limited to emergency first-aid care. Forty-hour week with rotating on-call duty. Salary negotiable in range of \$29,892 to \$40,272. Excellent benefits. Contact: H. D. Herrick, M.D., Superintendent, Norfolk Regional Center, Box 1209, Norfolk, Nebraska 68701. Call Collect: 402-371-4343.

PSYCHIATRIC RESIDENCY: Vacancies for (PG2 through PG4 only) positions starting July 1, September 1, 1978 and January 1, 1979 for those who have a regular Iowa license or can obtain one by reciprocity or via FLEX. Prepare for career in private practice, community clinics or hospital-based psychiatry. Emphasis on close supervision of intensive individual and group psychotherapy, OPD, Children's Unit, Adolescent Unit. Neurology affiliation with University of Iowa. The stipends are: 1st year, \$22,360; 2nd year, \$23,478; 3rd year, \$24,674. Intensity and diversity of training program appreciated best by personal visit. T. B. McManus, M.D., Superintendent, Mental Health Institute, Cherokee, Iowa 51012. Equal Opportunity Employer. Call collect 712-225-2594.

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"I'm allergic to my allergy capsules."

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Take one tablet b.i.d. for 10 to 14 days



...tion at urinary/vaginal/lower bowel sites helps
...inate reservoirs of infecting organisms

...distinctive antibacterial action plus wide spectrum
...as eradicate recurrent UTI

...w incidence of bacterial resistance in community
...ctice

...re prescribing, please consult complete product informa-
...a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morgani*. It is recommended for initial episodes of uncomplicated urinary tract infections treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonia. To date, this drug has been tested only in children 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (J. Clin. Microbiol., 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombocytopenia with purpura in elderly patients on certain diuretics, especially thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal function, possible folate deficiency, severe allergy or chronic asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, prothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, orbital edema, conjunctival and scleral injection, photosensitivity, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, diarrhea, diarrhea and pancreatitis. **CNS reactions:** Headache,

■ Convenient *b.i.d.* dosage provides day-and-night antibacterial control

■ Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarthritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children Two months of age or older:

Weight		Dose—every 12 hours	
		Teaspoonfuls	Tablets
lbs	kgs		
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonia:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see back cover.

Her next attack of cystitis may require

the BactrimTM 3-system counterattack



ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of

Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

BALCONY

*The Nebraska
Medical
Journal*

July, 1978



Front Runner



HYTONE[®] 2½% Cream (hydrocortisone)

for rapid control of the majority of inflammatory dermatoses seen in office practice — a logical alternative to the fluorinated steroids.

Followed by HYTONE[®] 1% or 1/2% Cream, for maintenance therapy and ultimate control.

Description: Hydrocortisone ½%, 1% or 2½% in a water-washable cream containing purified water, propylene glycol, glyceryl monostearate, cholesterol and related steroids, isopropyl myristate, polysorbate 60, cetyl alcohol, sorbitan monostearate, polyoxyl 40 stearate and sorbic acid.

Action: Topical steroids are primarily effective because of their anti-inflammatory, antipruritic and vasoconstrictive actions.

Indications: For relief of the inflammatory manifestations of corticosteroid-responsive dermatoses.

Contraindications: Topical steroids are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

Precautions: If irritation develops, the product should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly the corticosteroid should be discontinued until the infection has been adequately controlled.

If extensive areas are treated or if the occlusive technique is used there will be increased systemic absorption of the corticosteroid and suitable precautions should be taken, particularly in children and infants.

Although topical steroids have not been reported to have an adverse effect on human pregnancy, the safety of their use in pregnant women has not absolutely been established. In laboratory animals, increases in incidence of fetal abnormalities have been associated with exposure of gestating females to topical corticosteroids. In some cases at rather

low dosage levels. Therefore, drugs of this class should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

The product is not for ophthalmic use.

Adverse Reactions: The following local adverse reactions have been reported with topical corticosteroids, especially under occlusive dressings: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae, miliaria.

Dosage and Administration: Apply to affected areas 3 or 4 times daily.

How supplied: 2½% — Tube 1 oz., 1% and ½% — Tube 1 oz. and Jar 4 oz.

Caution: Federal law prohibits dispensing without prescription.

For Patient Starters Call Toll-Free (800) 523-6674

Dermik

Dermik Laboratories, Inc., Fort Washington, Pa. U.S.A. 19034

The Nebraska Medical Journal

EDITOR-FRANK COLE, M.D., No. 13, Bishop Square
3901 So. 27th St., Lincoln 68502

JULY, 1978

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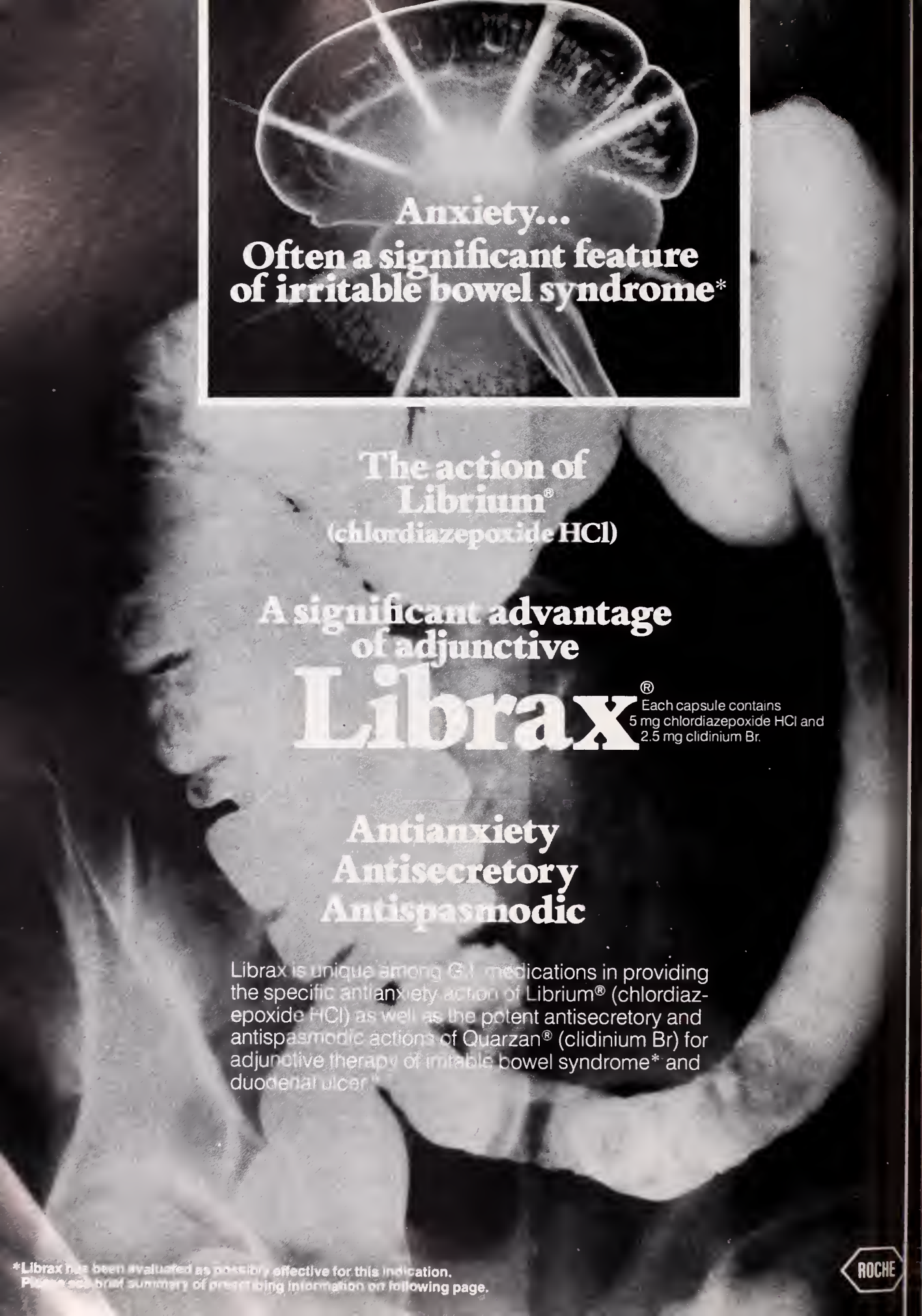
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Anxiety...
Often a significant feature
of irritable bowel syndrome*

The action of
Librium®
(chlordiazepoxide HCl)

A significant advantage
of adjunctive

Librax®

Each capsule contains
5 mg chlordiazepoxide HCl and
2.5 mg clidinium Br.

Antianxiety
Antisecretory
Antispasmodic

Librax is unique among GI medications in providing the specific antianxiety action of Librium® (chlordiazepoxide HCl) as well as the potent antisecretory and antispasmodic actions of Quarzan® (clidinium Br) for adjunctive therapy of irritable bowel syndrome* and duodenal ulcer.

*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on following page.

ROCHE

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE

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Ventricular Arrhythmia 24 Hours Before and After Maximal Treadmill Testing — H. L. Kennedy et al (US Public Health Service Hosp, Baltimore MD 21211) Am Heart J 94:718-724 (Dec) 1977.

To determine if maximal exercise treadmill testing influences the occurrence of ventricular arrhythmia in the hours after exercise, 45 myocardial infarction and 22 angina pectoris patients (New York Heart Association Class I-II) and 23 normal persons were examined with 24-hour ambulatory electrocardiographic Holter recordings before and after exercise testing. Comparison of qualitative and quantitative ventricular arrhythmia detected during identical chronological two-, four-, and 20-or-more-hour periods before and after exercise testing in each patient showed no statistically significant difference in any patient group. The prevalence of ventricular ectopy in 80% of the normal group as detected by 24-hour Holter recordings was similar to previous studies.

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Manuscripts (original, not a carbon) should be sent directly to the Editor at the Journal's address.

Letters to the Editor submitted for publication should be prepared as above, and must carry the notation: To be Published.

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DESCRIPTION Each tablet of PERCOCET®-5 contains 5mg oxycodone hydrochloride (WARNING: May be habit forming), 325mg acetaminophen (APAP).

INDICATIONS For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS Hypersensitivity to oxycodone or acetaminophen.

WARNINGS Drug Dependence Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of PERCOCET®-5, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, PERCOCET®-5 is subject to the Federal Controlled Substances Act.

Usage in ambulatory patients Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using PERCOCET®-5 should be cautioned accordingly.

Interaction with other central nervous system depressants Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with PERCOCET®-5 may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Usage in pregnancy Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, PERCOCET®-5 should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Usage in children PERCOCET®-5 should not be administered to children.

PRECAUTIONS Head injury and increased intracranial pressure The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions The administration of PERCOCET®-5 or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special risk patients PERCOCET®-5 should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

ADVERSE REACTIONS The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

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DOSAGE AND ADMINISTRATION Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. PERCOCET®-5 is given orally. The usual adult dose is one tablet every 6 hours as needed for pain.

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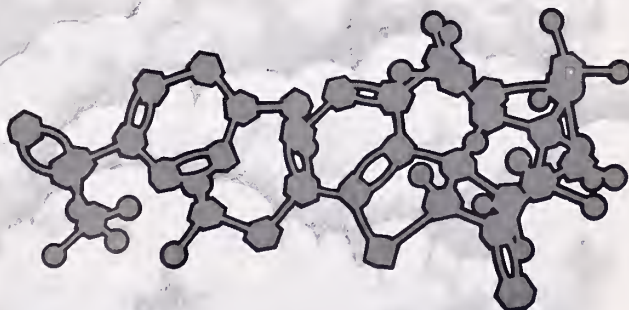
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Milk Allergy

While it is true that a certain percentage of the infant population may react adversely to milk proteins, actual incidence of milk allergy remains controversial.

Symptoms of milk allergy may include asthma, nasal congestion, vomiting, and abdominal pain. Since these symptoms also occur with other allergies and with other diseases, the condition may be improperly diagnosed as milk allergy. Some cite the incidence of milk allergy as being as low as 0.1 percent of infants, while others claim a figure as high as 30 percent. Most agree that the true range is between two and seven percent. Milk allergy is generally outgrown by age two.

Too often, a hasty diagnosis is made and milk is removed from an infant's diet and never replaced. The individual may then avoid dairy foods later in life. This may result in inadequate intake of the nutrients in milk, notably calcium, riboflavin, and vitamins A and D.

If milk allergy is suspected, the possibility of an improper diagnosis may be reduced by first removing milk from the diet for a two-week period of time. If symptoms remain after the two-week period, the physician must seek another cause and milk should be returned to the diet. If symptoms disappear after two weeks without milk in the diet, reintroduce milk to the diet. If no symptoms recur, they were possibly brought on by other than allergic reaction, and milk may remain in the diet.

Additional research must be performed to determine the actual incidence of milk allergy.

Dairy Council of Central States

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Unilateral Raynaud's Phenomenon in the Hand and Its Significance — J. Bouhoutsos et al (20 Alexandroupoleos St, Ambelokipi, Athens, Greece) *Surgery* 82:547-551 (Nov) 1977.

Unilateral Raynaud's phenomenon (RP) in the hand differs from Raynaud's disease in many aspects. The latter is a bilateral affliction often showing a remarkable symmetry of the digits affected. It may occur primarily without any arterial lesion when it is an exaggerated response to cold, or secondarily from digital artery stenosis or occlusion, usually in association with collagen disease. When primary it does not lead to trophic changes, but when secondary it progresses, in some, to serious ischemic lesions. In contrast, unilateral RP is always secondary to upper extremity arterial pathology either of a major vessel or of smaller vessels. In many the condition is progressive, leading to gangrene.

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Risks of Discontinuing Anticoagulant Therapy in a Selected Group of Patients With Atherosclerotic Heart Disease — P. Cote et al (Montreal Heart Institute, Montreal, Quebec, Canada) *Can Med Assoc J* 117: 1281-1284 (Dec 3) 1977.

Of 134 patients with coronary artery disease, 98 had acute myocardial infarction, 25 had acute coronary insufficiency, and 11 had severe chronic angina. Long-term oral anticoagulant therapy (mean duration, 56 months) was terminated abruptly in 50 patients (group 1) and gradually in 84 (group 2). The 134 patients represented a homogeneous population with coronary artery disease since most patients older than 75 years and those with conditions known to increase the risks of thromboembolic complications were excluded. The two groups were comparable in terms of sex, age, presence of risk factors, duration of anticoagulant therapy, and presence of angina and abnormal resting electrocardiograms during therapy. Patients were evaluated six months after cessation of anticoagulant therapy and, since abrupt withdrawal of therapy did not carry a higher risk than gradual discontinuation, data for groups 1 and 2 were tabulated together. Of the 84 patients with angina at the end of therapy 15 experienced an increase in its severity and this symptom appeared in another patient (relapse rate, 18%). Angina progressed to fatal acute myocardial infarction in four (mortality, 3%) and nonfatal infarction in two; however, all six patients had extensive coronary artery disease and poor left ventricular function.

Massive Upper Gastrointestinal Hemorrhage in the Elderly — F. C. Change et al (G. F. Farha, 905 N Emporia, Wichita, KS 67214) *Am J Surg* 134:721-723 (Dec) 1977.

Sixty-six elderly patients with massive upper gastrointestinal bleeding were retrospectively analyzed. This study supports the concept of vigorous resuscitation, early diagnosis with fiberoptic endoscopy, and prompt surgical intervention in patients with continued bleeding. When this approach was utilized in a community hospital, operative mortality was reduced to 5%.

**Brief Summary of Prescribing Information
Combined TEGOPEN® (cloxacillin sodium)
Capsules and Oral Solution**

For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established. **Precautions:** The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

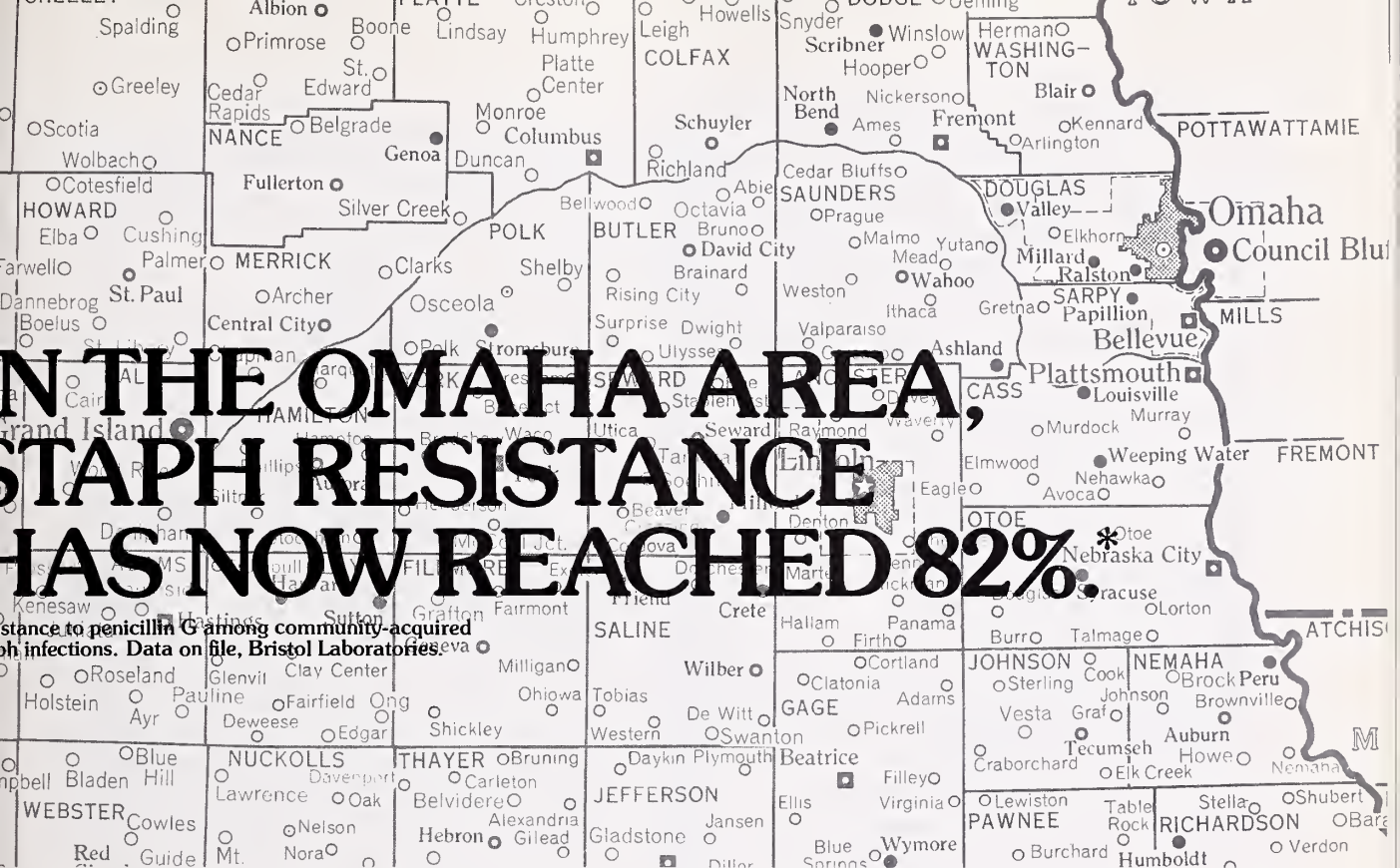
Usual Dosage: Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

Supplied: Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100. Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.





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Decreased Taste and Smell Acuity in Cirrhosis — R. E. Burch et al (Veterans Administration Hosp, Huntington, WV 25704) Arch Intern Med 138:743-746 (May) 1978.

The sensory modalities of taste and smell were evaluated in eight patients with cirrhosis (proven by biopsy specimens) and in 13 control subjects. Additionally, the following serum levels were determined: zinc, copper, magnesium, calcium, manganese, and selenium. Fourteen concentrations each of sucrose, sodium chloride, urea, and hydrochloric acid were used to evaluate taste acuity. Smell was evaluated with 11 concentrations each of nitrobenzene, thiophene, and pyridine. Decreased acuity of taste and smell occurred in conjunction with cirrhosis in the patients who were tested. There were no trace element abnormalities that consistently correlated with decreased acuity in perception of the individual test substances.

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THE NEBRASKA MEDICAL JOURNAL

WHAT MEDICINE NEEDS

What medicine needs today is a departure from old-fashioned rugged individualism and the I-know-what-is-best-for-you attitude. The only way to learn what is best for the patient is the statistical way, and one man's statistics are no longer enough. It is time we pooled the findings of all workers in all fields and came to statistically sound conclusions. Isolated registries are inadequate; they are needed wherever there is doubt, and there is doubt when one physician treats a condition one way, and another acts differently. I dislike the word regimentation, but this kind of regimentation is desperately needed, and it is time that we create an organization to collect, to consider, and to decide.

Hundreds of thousands of aortocoronary bypass grafts have been performed in this country, and most questions regarding its effectiveness have not been answered. Far more mastectomies have been done, and there is no uniformity of opinion. Can we not decide, nationally and not individually, if bypass graft should be done? And it is surely time to decide on the proper procedure for cancer of the breast in all its forms, so that given the same case, one surgeon does not perform radical mastectomy, another one modified radical, and a third simple excision with radiation.

These things should no longer be left to the individual physician; personal preference and whims must be cast aside. A national registry of medicine ought to be created, to study bypass graft and mastectomy, and everything else where there is doubt. One surgeon's enthusiasm for a particular procedure does not make that operation the correct one. Too many cases of coronary heart disease are being treated different ways: shall we operate or not? Too many women with breast cancer are being dealt with differently: radical, modified radical, simple?

Let us at once set up an organization to collect reports of cancer, heart disease, and all other uncompletely resolved conditions, so that the indication for an operation does not

depend on where you live, but on firmly established knowledge.

—F.C.

NO HISTORY, NO PHYSICAL,
NO LABORATORY

Suppose you asked a patient what his complaint was, and he said, you're the doctor, you find out; *you tell me*. And when you asked him to explain an incisional scar, he would not. Could you make a diagnosis purely by examining him?

A good doctor said, listen to the patient; he is trying to tell you the diagnosis. Suppose he would not be examined; could you diagnose from the history alone?

Suppose you had nothing but laboratory reports; no history and no physical. Could you make a diagnosis?

Instead of seizing on one method, could you eliminate one, the history, the physical, or the laboratory, and still find out what was wrong? Another good physician said he would open a second office, and practice there without a laboratory, and he expected to do well there.

How important is the history; is it all-important? How decisive is a careful examination? Do laboratory tests tell you everything?

I do not advise omitting the history, the physical, or the tests. But I wonder if they are of equal importance and if they are all significant. It may be that we don't need to see the patient at all, we might just look at the laboratory work.

Long ago, we were not allowed to examine queens and duchesses. We sat in an outer room and sent in questions, and ladies-in-waiting came out of the sick room with answers, and they pointed to dolls to show where the lump was, or where it hurt. And we diagnosed.

The question I raise is, how do we diagnose?

—F.C.

OUR NERVOUS SYSTEMS

Consider the autonomic, or sympathetic, or vegetative, or involuntary nervous system; and the central. You digest your dinner with one, and you talk with the other. But you can do some things with both.

Breathing is one. I can inhale or exhale whenever I want to, but when I forget, and when I sleep, my autonomic nerves luckily take over, and I go right on breathing if I do not have Ondine's curse.

But there are other things. I kick when I want to, or when a neurologist hits me with his little hammer. I can walk carefully if I choose, or I can do it without planning every step of the way.

Some have said that they could control their heartbeats and blood pressure, and we are easily led to other things. Diabetics are said to be able to lower blood sugar by meditating; can we fight disease by thinking right thoughts?

We may be led to psychoanalysis, and through analysis to a new field of treatment. If you do not mobilize calcium properly, you have only to think about it, in a newer system of medicine.

Meanwhile, there is breathing, and walking and kicking. I wonder why we can breathe both ways. We can cough when we want to; sneezing is different, it is hard to stifle a sneeze, and it is no easier to bring one on; I think you can yawn both ways. You can swallow with either system; and there is eye blinking; you can do it when you want to,

but you will do it anyway, all day long, without thinking about it.

Our two systems overlap; can this get us well?

—F.C.

THE ANNUAL SESSION

We met for four days, as we always do. The councilors sat and the delegates met three times; and the nominating committee listened and decided. A good president left and a good president took over; and a good president was elected.

When I was a resident, I used to take a lady to dinner and the dinner cost 50 cents, and I just found out why medicine costs so much. I bought a sweet roll to eat just before the delegates met, and the roll cost me 67 cents.

I didn't get elected president, but they chose a better man. I couldn't preside, but I'll bet he can't edit. Our athletic luncheon speaker was wonderful, and I drove him to the airport when he was late and couldn't get a cab.

The reference committees worked hard and so did the girls who typed what the committees said; the hearings were thought-provoking and were excellent.

Annual sessions are interesting and fun, and they are work, and those who do not come must know how hard the councilors and delegates and officers labor in behalf of the nonworkers.

It was a wonderful meeting.

—F.C.

Remarks to The House of Delegates Nebraska State Medical Association

April 30, 1978

Mr. Speaker, members of the House of Delegates, distinguished guests.

I find it a real pleasure to be able to personally present this report to the House of Delegates. I regret that I was unable to attend your meeting last fall because of a prior commitment. Actually, the timing probably is more favorable since I can speak to you today with almost a year of experience as Chancellor of the Medical Center.

I would like to share with you some impressions of the Medical Center I have formed during the past ten months and would also like to outline areas where progress has been made and areas where problems have not yet been solved.

One of the first issues brought to my attention in Nebraska was that of rural health and the role the Medical Center should play in the solution of statewide problems of this type. Last summer I appointed a task force to explore this issue. The task force was chaired by Dr. Paul Young, Chairman of our Department of Family Practice. It has submitted a preliminary report which contains a number of observations and recommendations. Our Rural Health Task Force was composed primarily of full-time faculty and staff but did include Dr. Tollefson from your Rural Health Committee as well as Dr. Leo Lucas, the Dean of the University's Cooperative Extension Service in Lincoln. It maintained a close liaison with the Governor's Commission on Rural Health and continues to do so. We are already making some progress in implementing the Task Force's recommendations.

The Task Force noted that we have received relatively few applications to medical school from students in rural areas. In fact, in the past year, 55 counties in Nebraska produced a total of only 22 applicants to the College of Medicine. All of these counties were rural counties. In an

NEIL VANSELOW, M.D.

effort to interest more rural students in health careers, a group of Medical Center students have organized a program aimed at high school students in smaller Nebraska communities. On their own initiative, the students prepared a slide-sound presentation and are visiting communities in the state to meet with high school students, high school counselors, health professionals, and other community leaders. The program describes careers in health and is being taken by the student teams to several rural communities this month.

As another element of its program in rural health, the College of Medicine has increased the duration of its rural health preceptorships for medical students from four weeks to eight weeks. I believe it is valuable for medical students to learn about good medicine as it is practiced in a rural area at an early and formative stage of their careers.

One recommendation of both the Governor's Commission and our Task Force was the establishment of a student loan forgiveness program. As you may know, Senator Richard Maresh introduced a bill in the legislature to begin such a program. This bill, LB 884, was passed, signed by the Governor, and goes into effect next year. For each year of practice in a shortage area of the state one year's loan incurred during medical school will be forgiven. I believe this program has a good chance of success. Certainly, our students have expressed great interest in it.

The Medical Center has also received a grant from the W. K. Kellogg Foundation to study and perhaps implement a statewide residency program in primary care specialties in cooperation with Creighton and the

Lincoln Medical Education Foundation. This grant also will finance a study of the feasibility of establishing a Family Practice residency in the Grand Island-Kearney-Hastings area, a program which has been urged by members of the legislature and others.

In cooperation with the University's Cooperative Extension Service, the Medical Center has written a grant proposal proposing a health education program for the public in six rural areas of Nebraska. Should this proposal be funded, we believe it will enable rural residents to more effectively use the health care resources available to them.

Before leaving the subject of rural health I would like to reemphasize something we have stressed before. While the Medical Center is fully committed to doing its part to find solutions to the rural health problem, it cannot solve this problem alone. Any final "solution," and I hesitate to use the term solution because the problem is a complex one and will in fact need "many solutions," will require the help of state government, your help, and the help of rural residents themselves.

Turning to another area, last fall we organized a Task Force on Research at the Medical Center. This task force just recently made its report to me. Since the report has not been circulated to all members of our faculty as yet, the only comment I can make at this time is that the task force concluded we are doing considerably less research at the University of Nebraska Medical Center than is being done by comparable medical centers around the country. We do need to improve our track record in this important area of endeavor, the task force has made a number of specific recommendations, and we will be implementing these recommendations during the next year.

As you know, considerable effort on the part of many individuals was spent during the first half of the 1977-78 academic year to develop a new plan to handle professional fee income generated by clinical faculty in the College of Medicine. A plan was developed and approved both by a large majority vote of the clinical faculty and by the Board of Regents.

The new professional fee plan, which goes into effect in July of this year, provides what I consider to be adequate reporting and control mechanisms while at the same time retaining the incentive principle. As an aside, I would congratulate both the faculty of the College of Medicine and the Regents for the considerable restraint they have exercised in dealing with what is always a controversial matter in a medical school.

I would also like to comment briefly on the Medical Center's budget for the coming year. It is lean and it is tight for both the Medical Center and the entire University. There is no money for new programs, no money for improvement in existing programs, and essentially no new money to enable the Medical Center to cope with inflation in the costs of goods and services.

The University's emphasis this year was on the improvement of faculty salaries, but to reach the 8% increases directed by the Regents the University will have to use up to \$2 million in cash funds which are available on a one-time basis only. Needless to say, we anticipate a cautious year ahead.

Finally I would like to report on the progress which is being made in the search for a new dean of the College of Medicine. As you know, Dean Perry Rigby announced his resignation in February. A search committee was appointed immediately and is now hard at work. In addition to representatives from the full-time faculty, the search committee membership includes Dr. Tollefson, Dr. Charles McLaughlin, and Dr. Gerald Schenken from our part-time and volunteer faculties.

In conclusion I would like to pledge that I will do everything possible to maintain a close working relationship between the Medical Center and organized medicine. In past positions both in Michigan and in Arizona I have always tried to do this because I believe that a relationship of this type is of vital importance to any academic medical center. I believe that by working together we can achieve a great deal in improving health care in Nebraska and I welcome this opportunity to become better acquainted with each of you.

Thank you for inviting me to your meeting.

The Tragedy at the Norwalk, Connecticut Drawbridge, or The Dangers of Attending a Medical Convention in 1853

WHEN we go to a convention today, not much consideration is usually given to the risks involved in traveling although these are real. However, traveling to a meeting 100 years ago was much more of a dangerous adventure. An example of such a danger was the tragedy that occurred at the Norwalk, Connecticut drawbridge on May 6, 1853.

The 6th annual meeting of the American Medical Association convened in the Blecker Street Presbyterian Church, New York City, at 11:30 AM, Tuesday, May 3, 1853.¹ This was the first time a meeting had been held in New York City although the first organizational meeting of the National Medical Convention — which was to become the American Medical Association — had met there 7 years before.²

The audience numbered 573. At that time in the history of the AMA, attendance at the annual meeting was limited to a set number of "delegates . . . from permanently organized medical societies . . . (whether state, county or local), medical colleges, hospitals, lunatic asylums and other permanently organized institutions of good standing" plus physicians by invitation.³

It is interesting that, as a reflection of the sectionalism that there was even then — 8 years before the beginning of the Civil War — stressing the nation, the delegates were listed in the Transactions by states in order of the section of the country rather than listing the states in alphabetical order: first came the New England states, and then followed the mid-atlantic, southern, mid-western and, lastly, California. Two from the Navy and three from the Army represented the military and from foreign countries (accepted by invitation) were two from the American Medical Society of Paris, one from "Beyroot, Syria" (a Dr. Robert R. Kalley), and one from "Canada West."

WALT J. FRIEDLANDER, M.D.
Center for Humanities and Medicine
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The meeting's agenda consisted largely of business interspersed with a few professional papers. The titles of some of the papers do not sound at all strange to our modern ears, such as "Results of Surgical Operation in Malignant Diseases" or "Acute and Chronic Diseases of the Neck of the Uterus," but some titles betray the times that they were delivered, such as "An Inquiry into the Nature of Typhoidal Fevers" or "On the Agency of the Refrigeration Produced by Upward Radiation of Heat as an Exciting Cause of Disease."⁴

The general topics in the business portion of the meeting sound familiar: concern about the government and about medical education.⁵ A couple of special items of interest were that dues were set at \$5 and that it was moved, and after a goodly amount of discussion, passed, that "no member be allowed to speak more than ten minutes on any one subject at one time, nor more than twice on the same subject."

The evenings after the meetings were spent in the appropriate fashion. There was available to the visiting doctors all the gaiety of the big city. Franconi's Hippodrome was presenting Restoration of the Festivals, Games, and Amusements of the Ancient Greeks and Romans with reserved seats at \$1, boxes at 50c and the pit at 25c. Macbeth was playing at the Broadway Theater and a comedy entitled Begone Dull Care was at Burton's Chamber Street Theater. At Barnum's American Museum there was the Drama of the Willow Copse and Mr. John Owen's

Alpine Rambles; Ascent of Mont Blanc was in its fifth week at the Chinese Saloon. They could stop and have their photographs taken at Bogardus Daguerreotype Establishment which advertised, "We do not, never have, and never will take pictures on a Sabbath . . . (and) We do not, never have, and never did take the trash called 25 cent pictures." Or, the doctors could see at the American Institute's fair the gold medal that had just been awarded to Hood and Sanderson for the best exhibited truss.⁶

The New York Daily Times noted that . . . "the Medical Association now in session is doing great work during its recesses — properly comforting the body while the intellectual man is being refreshed . . . (On Tuesday evening) some of the great citizens . . . (including the mayor) opened their houses to the delegates . . . (and on) Wednesday evening the great dinner of the occasion comes off at the Metropolitan." Again, as a reflection of the political forces that were straining the country 8 years before the south seceded, the reporter added, "This is the way to save the Union . . . Let the stout men of the Nation eat together. It would come hard for a man who has helped another to ice cream and jellies, to thrust sharp steel in between his ribs, or seek to shed his blood, unless it be to relieve him of some acute and sudden inflammation." This, of course, had reference to a favorite form of treatment in those days, bleeding. The Times then congratulated the Association on its accomplishments and the report ended with the salute, "May the members relish palatable viands and find their digestion none the worse therefor."

For those who saw the Monday, May 2nd,⁷ or the Tuesday, May 3rd, New York Daily Times,⁸ they could have read about the Michigan Central railroad accident that had killed at least 15, a wreck of a train from Augusta in which the engineer was so badly injured that "his recovery is doubtful," and about someone suing because of still another railroad accident.

The minutes of this meeting, as published in the Transactions, ends on the afternoon of May 5th with the note, "The Association then adjourned sine die." But, below this, on the same page but in smaller print, is an

addendum: "A special meeting of the members of the American Medical Association remaining in New York was held on the 12th day of May . . . Dr. Smith . . . stated that, by the request of a number of members of the Association, the Secretary had called a meeting of the delegates resident in city and its vicinity and such as were remaining here from abroad for the purpose of expressing their feelings respecting the late disaster on the New Haven Railroad, at Norwalk in Connecticut which resulted in the death of so many valued members of the Association and that now for the members present to adopt such measures as they saw fit to carry out the object in view."⁹

On Friday, May 6th, the New Haven train left New York for Boston at 8 in the morning. Mr. Charles H. Comstock was the conductor and Mr. Edward W. Tucker, the engineer. According to railroad company rules, the conductor was in charge of the train and, as such, responsible for seeing that it kept its schedule; however, the engineer was responsible for observing and obeying the signals.

Mr. Tucker, the engineer, was a relatively experienced pilot in this new industry. He had been an engineer since 1849. Back in January, 1851 while running the New York to Bridgeport train he had been involved in an accident. His train was on a single track line. He wanted to wait on a siding for a late oncoming train but his superior, the conductor, had ordered him to proceed and a collision followed. Mr. Tucker was adjudged not responsible for the accident but he did suffer sufficient injuries so that he was put on sick leave, with pay, for a year. He had started back to work for the New Haven on a full-time basis in March, 1853. On the fateful morning of our story, he was driving the train for his first time on this particular run. He must not have been very anxious about the trip since he spent at least part of the time reading the newspaper.

Two hours after leaving New York, the train was approaching Norwalk, where, according to the language of the time, it did not "land," in other words, did not stop. The train was eight minutes late and apparently trying to make up time.

The drawbridge just after the city had been opened to allow the steamer, *Pacific*, to pass and had not yet closed. This should not have been of much concern. The signal to stop the train — low ball — was out; it had been lowered about 14-15 minutes before the train arrived.

The track was wet and slippery and the train was going faster than it should. Witnesses estimate its speed at 35 miles an hour although the engineer and the fireman said that they were only going 15-20 miles an hour and the conductor, over whose head lay the major indictment, estimated the speed at only 10 to 12 miles an hour. But in any case, the speed was too great.

As the train approached the Norwalk station, it went through a cut and from there to the drawbridge was about 3300 feet. Over this 0.6 mile, the low ball signal could be seen only intermittently because of the landscape and buildings. The engineer failed to see the warning signal until too late. Seconds before the train reached where the drawbridge track should have been, he blew a warning whistle and then the locomotive flew over almost the entire width of the span — 60 feet — and crashed against the wall on the opposite side. The engine, baggage car, and 2 of the 3 passenger cars plunged into the river, 15 feet deep, and the last car broke in half with the front part following the rest of the train into the water.

Forty-six passengers died, 8 were reported missing, and about 141 were injured. Among the dead were 7 of the physicians who had just left the AMA meeting; a number of other physicians were injured, perhaps as many as 21.¹⁰⁻¹⁴ The magnitude of this tragedy was such that if the same percent of the registrants at a recent AMA convention had been killed, this would have amounted to about 100.

The dead physicians were: Archibald Welch, 59, of Hartford, Connecticut; Abel Pierson, 59, of Salem, Massachusetts; William Dwight, 54, of Moscow, Livingston County, New York; Samuel Beach, 51, of Bridgeport, Connecticut; Josiah Bartlett, 50, of Stratham, New Hampshire; James M. Smith, 48, of Springfield, Massachusetts; and James Gray, 34, also of Springfield.¹⁵

It is difficult to get any general picture of what sort of men these unfortunate doctors were. Their obituaries describe them with the usual funeral glorification. In addition to the usual praise, at least the five older physicians were given special commendations for their piety and temperance.

There were, however, some interesting things about several of these men. Dr. Welch had been active in politics and had served two terms in the Connecticut state legislature.

Dr. James Smith was the son of Dr. Nathan Smith, famous in American medical history as having established medical schools, successively, at Dartmouth, Yale, Bowdoin and the University of Vermont. James Smith was a prominent surgeon. While he was living in Baltimore, Maryland he became well known for having successfully done a bilateral thigh amputation on an injured patient "without the aid of any anesthetic agent to obviate the shock." After he moved to Springfield, Massachusetts, according to his son (who was also a physician) ". . . he either performed or was present as senior consulting surgeon at every operation of any importance that was performed in the place or its vicinity; and, what is remarkable . . . although his surgical operations were exceedingly numerous and difficult, embracing amputations of the thigh, leg, shoulder joint, forearm, and mamma, tying the femoral artery, operations for hernias, etc. he . . . (never), from their effects, lost a single patient." This is, indeed, a remarkable record particularly when we recall that anesthesia had first been introduced only 7 years before and was not widely used and that Lister's introduction of antiseptic surgery was still almost 20 years in the future.

Dr. Dwight had been a student of Dr. James Smith's father. He was described as one of the most eminent physicians and surgeons in western New York; he had experimented with chloroform and apparently had used it freely.

Dr. Abel Pierson was a remarkably progressive physician. He was among the first to use the stethoscope in this country. He was also one of the first physicians to use ether. On November 6, 1846 he was in

attendance at the Massachusetts General Hospital when Dr. George Hayward performed the first amputation under ether. This was just 3 weeks after Dr. John C. Warren first used ether. (A "Dr. Warren of Boston" was listed as "badly but not fatally injured" in the Norwalk train wreck). Pierson was impressed enough with this new technique that two weeks later he amputated a young lady's arm under ether anesthesia and was, therefore, credited as only the second person to do this.

Pierson had been prominent in the activities of the recent AMA meeting. He had been a member of the meeting's Nominating Committee as well as a member of the Committee on Plans of Organization for State and County Societies. He was also the one who suggested the design for the stone that the American Medical Association ultimately gave as their contribution to the building of the Washington Monument.

The Washington Monument was conceived in 1833, begun in 1848 and finally completed in 1884.¹⁶ It had many problems, mainly financial, and one method of coping with this was to invite organizations to contribute a stone with a commemorative plaque. The year after the Norwalk accident, at the 7th annual AMA meeting, Dr. Atlee revealed that it was Dr. Pierson's suggestion for a design that would mark the Association's stone, a scene "... representing Hippocrates refusing the presents of the ambassadors of King Artaxerxes who invited him to go to Persia and succor the enemies of Greece."¹⁷ The following year, 1855, at the Philadelphia meeting, Dr. Atlee announced that the stone was completed and on exhibition "in a lower room of the building" and "... took occasion

to solicit further subscriptions from members of the Association in order to remunerate more adequately the labors of the young artist who had produced the work."¹⁸ The Treasurer's Report at the 1856 meeting notes, "To cash, paid Dr. Jno L. Atlee of Commission on Washington Monument Stone, \$498.70."¹⁹ And so, the late, lamented Dr. Pierson was, in a fashion, commemorated, in perpetuity, in the Washington monument.

It was prophetic that Dr. Pierson's friends had urged him to take the boat back home because it was safer and he had even written home that he was going to return by steamship. But, apparently, at the last minute he changed his mind saying that he thought the train was "secure." Similarly, Dr. Bartlett, the grandson of a signer of the Declaration of Independence, had turned down an offer to stay with friends in New York because he was apprehensive about traveling. His concern had been aggravated by a recent experience. When he had last visited New York, he had originally arranged to return home on the steamship Lexington but he was late at arriving at the dock; that ship burned during the trip with a loss of most of the passengers.

This particular train wreck represented, independent of its relation to the AMA, a notable episode in the history of American railroading. From the standpoint of the number of fatalities, it was the worst accident in the year that first marked trains as a very dangerous method of transportation.²⁰

References may be obtained from the author.

Mammography: Advantages and Indications

CARCINOMA of the breast is the most common malignant tumor of females, and is the leading cause of death among women between the ages of 40 and 44 years.¹ An estimated 33,000 women of all ages will die of the disease this year, and 88,000 new cases will occur.² In fatal cases, the cost of medical management during the average span of four and one-half years between discovery and death has been estimated at more than \$100,000 per case, disregarding the patient's personal expense and suffering.³ Although medical science has reduced the toll of many of the more common cancers, the incidence and mortality figures for carcinoma of the breast have remained stubbornly unchanged for over 30 years.⁴

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Both film mammography and xeromammography are painless, reliable, and relatively safe methods of evaluating the breast. They differ in that xeromammography makes use of a photoconductive selenium plate and paper print rather than film to display the image. Both methods use x-rays to create the image. Other methods of breast examination, such as ultrasound, thermography and radio-nuclide techniques are presently regarded as too unreliable or insufficiently developed to be clinically useful. The purpose of this paper

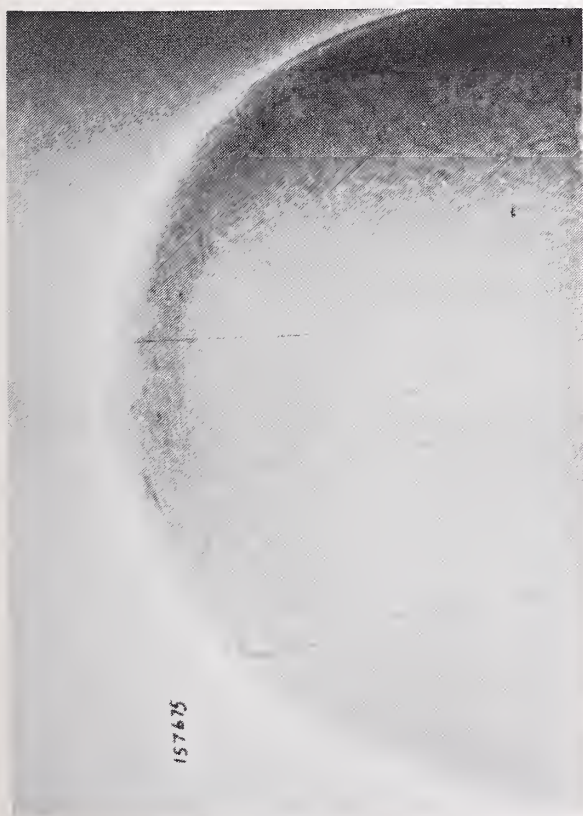


Figure 1
Xeromammogram. Normal breast.

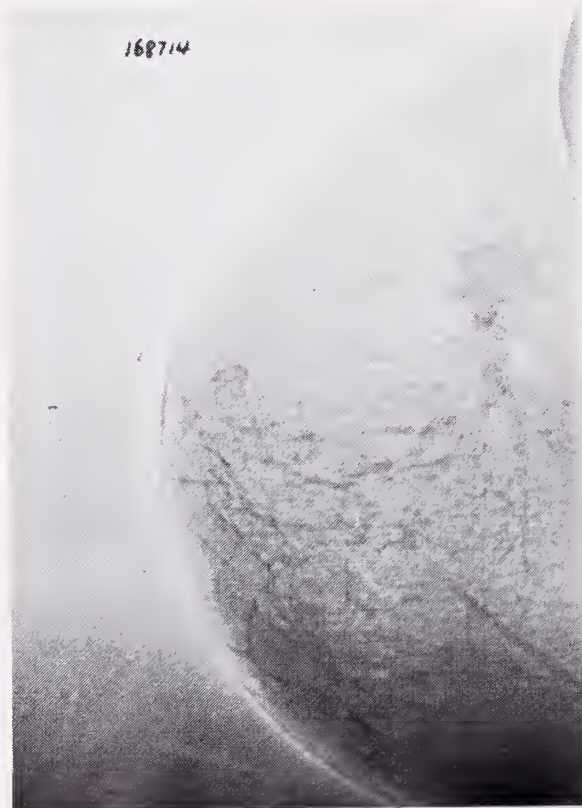


Figure 2
Xeromammogram. Large irregular mass typical of carcinoma.

is to review some of the current controversy regarding mammography, and to outline its indications and results.

Most of the debate surrounding mammography stems from the potential health hazards of exposure to ionizing radiation.⁵ This has become a popular issue in the lay press, and this in turn has given rise to considerable confusion and apprehension among the general population, and to some extent within the medical profession as well.

First, a realistic assessment of the degree of risk from mammographic examination is necessary. At present, the lifetime occurrence rate of carcinoma of the breast in the general population is one in fifteen, or 7%. Authorities estimate that radiation from xeromammography might increase this incidence, but that the increase would be less than one-tenth of one percent, to 7.07%.⁶ This brings the risk/benefit ratio into a clearer, and we believe, less cataclysmic perspective.



Figure 3
Xeromam Spiculated mass typical of carcinoma.

Another source of confusion has been the phrase: routine screening of asymptomatic females. This needs clarification. There is general agreement that mammography is indicated routinely in females past the age of 50 years, and in patients of any age with clinical signs or symptoms of cancer. There also seems to be general agreement that mammography is probably not indicated in the asymptomatic female under the age of 35. The dispute is over the rational approach

TABLE 1

Wolfe's Classification by Mammogram Pattern

- N1 — Lowest Risk —
Parenchyma composed primarily of fat with at most small amounts of dysplasia. No ducts visible.
- P1 — Low Risk —
Parenchyma chiefly fat with prominent ducts in anterior portion up to one-fourth of volume of breast. Also, may be a thin band of ducts extending into a quadrant.
- P2 — High Risk —
Severe involvement with prominent duct pattern occupying more than one-fourth breast volume.
- DY — Highest Risk —
Severe involvement with dysplasia. Often obscures an underlying prominent duct pattern.
- QDY — Intermediate —
Women below age 40-45 whose degree of dysplasia is not severe, and whose pattern may change with age and not reach a stable pattern until age 45-50.

Data from Wolfe⁸

TABLE 2

Projected Lifetime Risk of Developing Breast Cancer for 40-59 Age Group

Group	Projected risk for remainder of lifetime [per 1,000]	% of Population in this classif.	% of Cancers
N1	20	35%	5%
N1 and P1	30	63%	14.5%
General Population	56		
P2 and DY	176	36.6%	85.5%
DY	448	12%	47%

Data from Wolfe. (Assumes 15% of the cancers occur before age 40).⁸

TABLE 3

Archbishop Bergan Mercy Hospital Study of 1250 Consecutive Xeromammograms

Total number carcinomas found using both physical and mammographic exam	52
Carcinomas found by Xeromammography	47
Carcinomas found by physical examination	28

to the asymptomatic female population between the ages of 35 and 50 years. Recently, several authorities have attempted to clarify this problem.

In an excellent recent editorial Holleb⁷ has pointed out some of the merits of breast screening programs aimed at females between the ages of 35 and 50.

As a broad guideline, the American College of Radiology has suggested that an initial, or baseline mammogram be obtained at age 35-40.⁶ Ideally, this study would be performed one week after menstruation, minimizing the possibility of pregnancy, and reducing hormonal influences on the radiographic appearance of the breast. Follow-up examinations are then recommended at one to three year intervals, unless the development of clinical signs or symptoms warrants more frequent evaluation.

Since our own experience is predominantly with xeromammography, we are attempting to adapt the method of John N. Wolfe,

M.D.⁸ According to the xeromammographic appearance of the breasts, patients are placed in one of four "risk categories" at the time of initial examination (Table 1). The approach to their follow-up is then determined by the relative risk of each category (Table 2). Thus, for patients in the group at lowest risk for the development of breast cancer, reexamination would not be recommended at all, unless or until a clinical suspicion of cancer were aroused. For those in the group at highest risk, examination would be recommended at yearly intervals, unless clinical developments warranted more frequent evaluation. The groups at intermediate risk would be examined less frequently, again with a view to the clinical situation. It cannot be overemphasized that mammography is an adjunctive method, and is not intended to replace physical examination. Although there is at least one group which disagrees with Wolfe's approach,⁹ we feel that the above method provides a practical and rewarding aid in the early

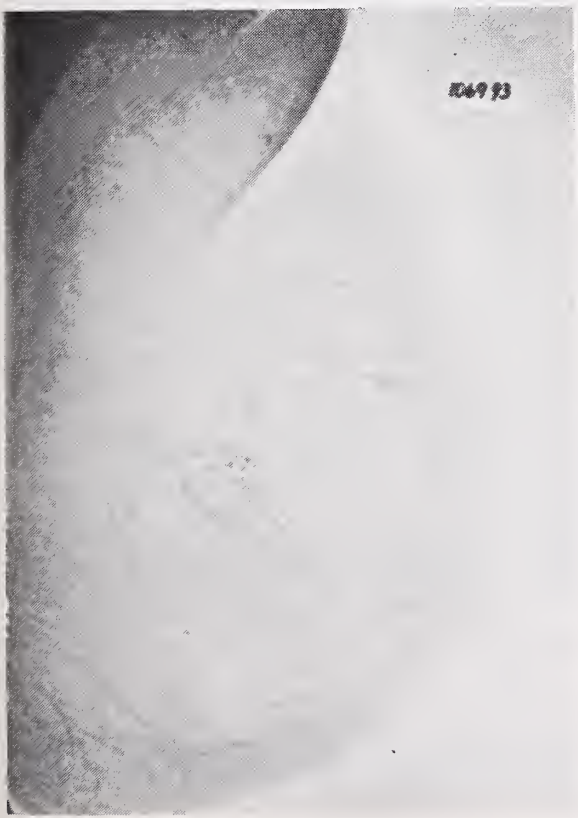


Figure 4A
Xeromammogram. Cluster of tiny calcifications typical of carcinoma.

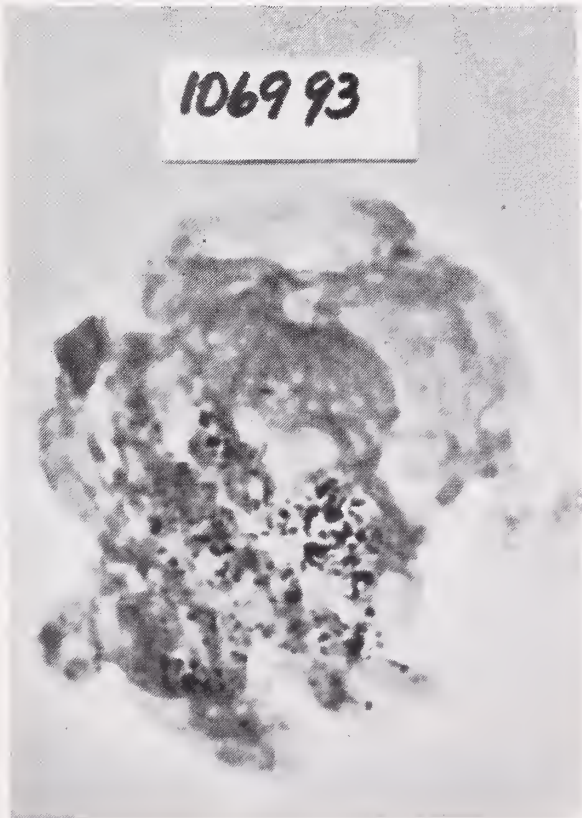


Figure 4B
Specimen xeroradiograph confirming suspicious area is included in biopsy.

detection of breast cancer, while reducing the number of "unproductive" examinations.

In a series of 1,250 patients referred for Xeromammography at this institution, 52 malignancies were discovered in 50 patients. While 28 of these were palpable at physical examination, 24 were discovered by x-ray that were otherwise not detectable. Of the 28 clinically suspected lesions, there was positive Xeromammographic correlation in 23. Five clinically evident cancers were not apparent at xeromammography (Table 3). We feel that the discovery of 24 otherwise undetectable lesions is a significant advance.

Perhaps a word is in order regarding accuracy. Although there are some instances in which the diagnosis of malignancy can be made with relative certainty, and others in which the diagnosis of benignancy can be made with equal confidence, we feel that one is misguided to approach mammography with the idea of being right or wrong. We are, after all, aiming at the detection of early, and hopefully occult lesions. The signs of occult malignancy are subtle, and the differences between benign and malignant lesions often are not great. We therefore tend to recommend biopsy in any questionable circumstances.

It is important to note, particularly with regard to occult lesions, that a negative biopsy does not necessarily preclude malignancy, since it is possible to excise a portion of the breast which does not contain the mammographically suspicious tissue. Specimen xeroradiography, a technique which lies beyond the scope of this paper, has been developed to avert this by confirming the presence of the questioned area in the surgical specimen (Figs. 4A and 4B).

We feel that film mammography and xeromammography are useful and reliable adjuncts in the early detection of mammary carcinoma, and that rationally applied, they make a significant contribution to this end without undue risk to the patient.

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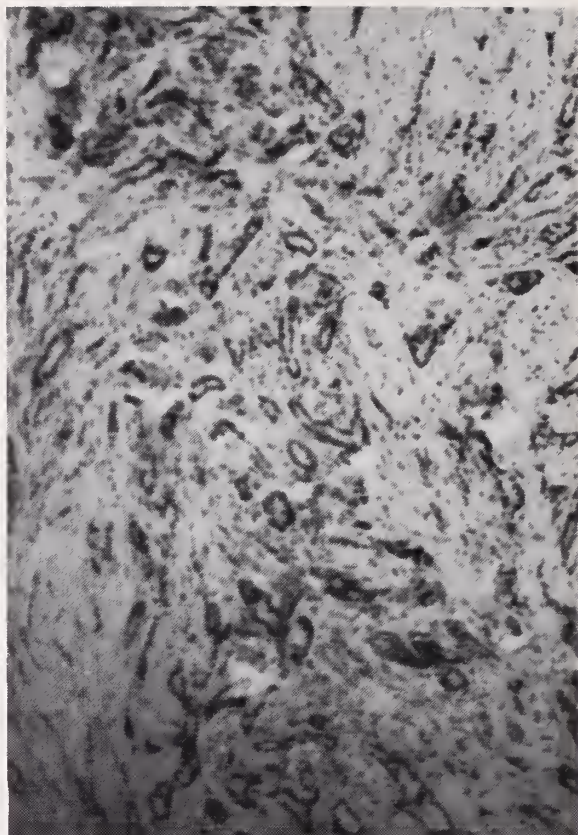


Figure 5
Microphotograph showing typical pathological findings of carcinoma. [Courtesy of John F. Fitzgibbons, M.D.]

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Oxygen Transport

THE tension or pressure of oxygen in the average alveolus of the lung is directly related to the partial pressure of oxygen in the inspired atmospheric air (Dalton's Law). At sea level the barometric pressure is approximately 760 torr and the oxygen tension in dry air is about 159 torr (20.9 percent of 760 torr). Upon heating and humidifying the gas to body temperature and humidity, the oxygen pressure falls to 149 torr because of the addition of water vapor with a pressure of 47 torr [20.9 percent of (760 - 47) torr]. (Figure 1) In the average alveolus the oxygen tension is further reduced to approximately 100-105 torr, due to equilibration with capillary blood and the addition of carbon dioxide to the alveolar gas. The tension of oxygen in the pulmonary end-capillary blood is, therefore, approximately the same as the tension in the adjacent alveoli except for a

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small diffusion gradient of 1 torr or less. (Figure 2)

The arterial oxygen tension (P_{aO_2}) is normally 5 to 10 torr lower than the calculated alveolar oxygen tension (P_{AO_2}), due primarily to shunting of unoxygenated blood into the left atrium from the bronchial and Thebesian veins. Alterations in the distribution of ventilation and perfusion within the lungs also contribute to the alveolar-arterial oxygen gradient.¹ (Figure 3)

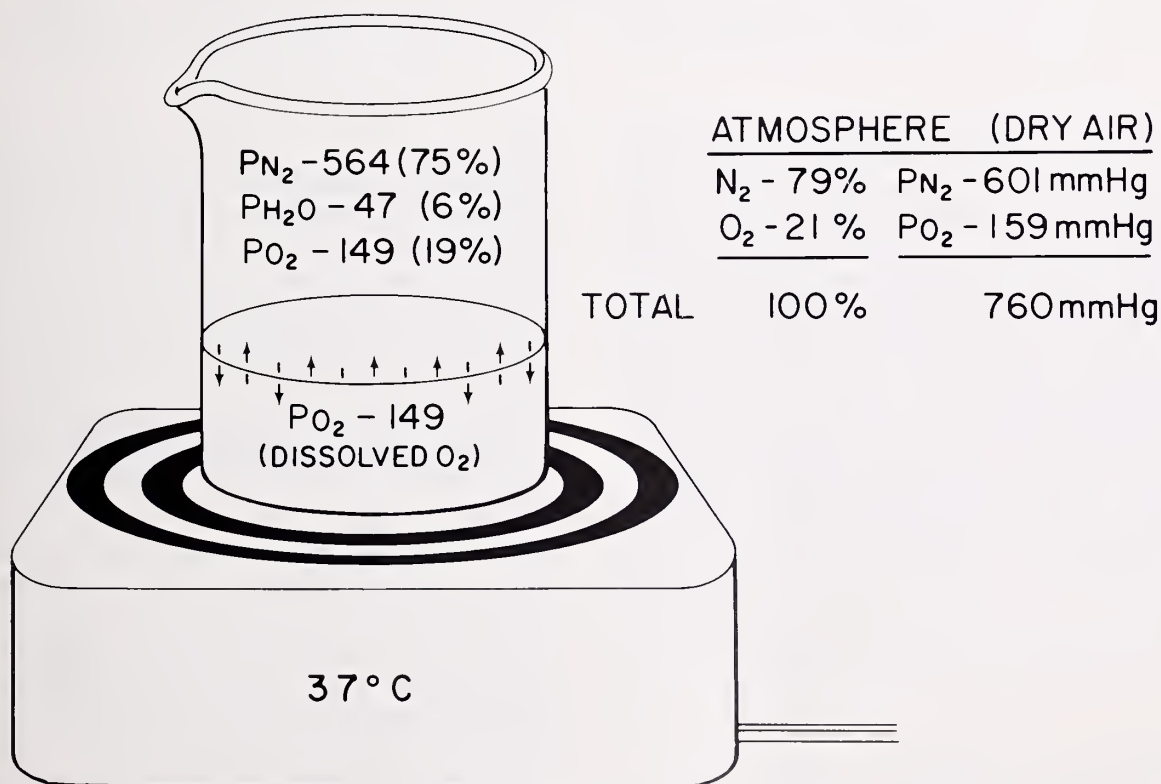


Figure 1
Partial pressures of the gases in atmospheric air and pressure of oxygen dissolved in a liquid at 37° C.

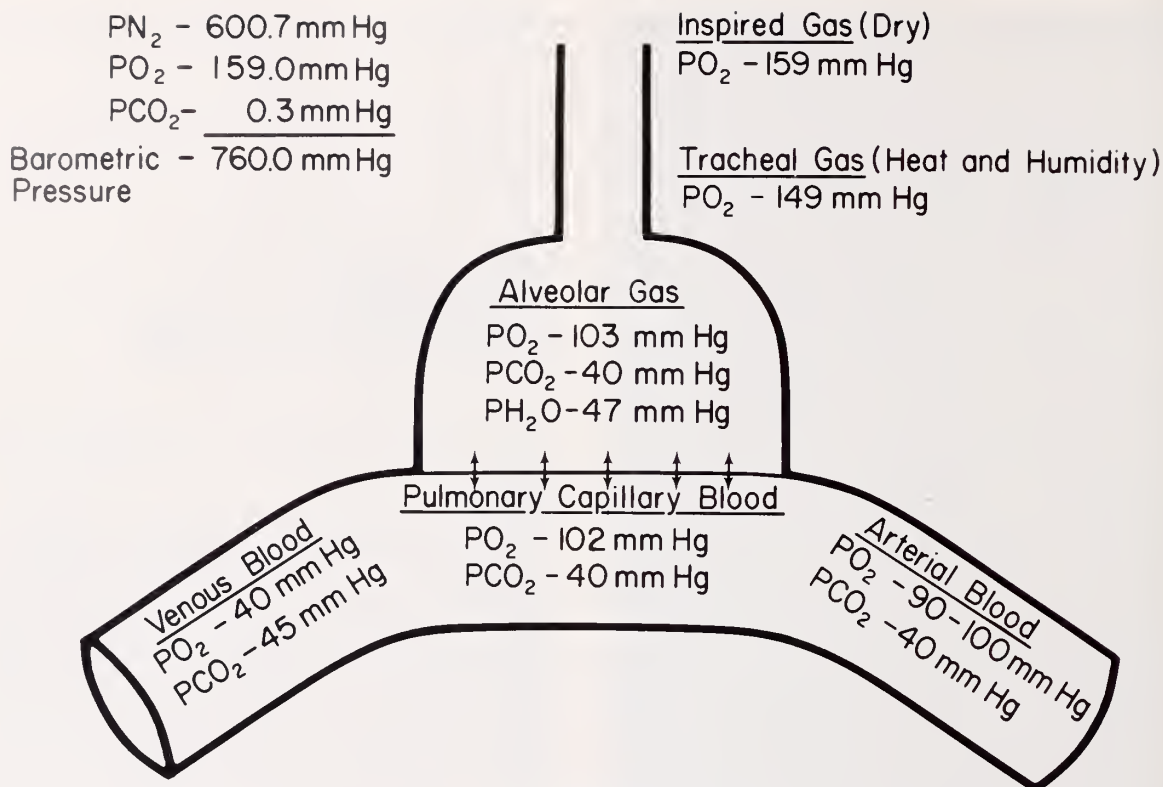


Figure 2
Partial pressures of gases in an average alveolus and in venous and arterial blood.

During normal tidal breathing, approximately four times more ventilation goes to the bases of the lungs than to the apices. Perfusion is also distributed regionally, with about 18 times more blood going to the bases than to the apices.² This unequal matching of ventilation to perfusion accounts for lower tensions of oxygen and higher tensions of carbon dioxide in the alveoli at the base of the lungs, and it is responsible in part for the alveolar-arterial oxygen difference. (Figure 4) The average alveolar oxygen tension may be calculated by the following equation:

$$P_{AO_2} = (BP - 47) F_{IO_2} -$$

$$P_{ACO_2} \left[F_{IO_2} + \frac{1 - F_{IO_2}}{R} \right]$$

The normal PaO_2 in healthy young adults at sea level is 90-100 torr. At both extremes of life the PaO_2 may be as low as 60-65 torr. The alveolar surface of the lungs is about 60 to 90 square meters with the pulmonary capillary volume approximately 70 ml. At sea level gas exchange occurs within about 0.3 of a second and because of the enormous efficiency and reserve of this system, arterial blood gases remain within normal limits even with strenuous exercise when disease is not present.

The physically dissolved oxygen in the arterial blood accounts for only a small fraction of the total oxygen that is available to the tissues. Sixty times more oxygen is normally carried by the red blood cells than is physically dissolved in the plasma. Venous blood returning to the lungs is about 75% saturated with oxygen. By the time blood has traveled about one third the distance through the pulmonary capillary bed, the hemoglobin has become fully oxygenated,

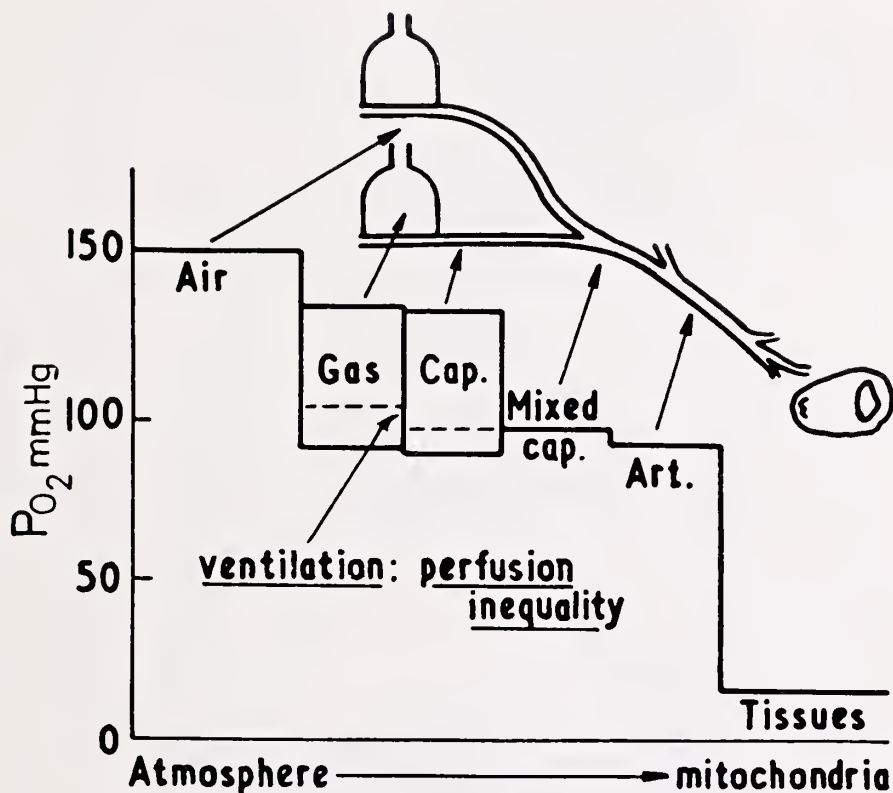


Figure 3

The effects of ventilation-perfusion inequality, shunt and diffusion on arterial PO_2 . [Reproduced by permission of J. B. West and Blackwell Scientific Publications, Ltd., VENTILATION/BLOOD FLOW AND GAS EXCHANGE, Page 13, 1977].

tions, Ltd., VENTILATION/BLOOD FLOW AND GAS EXCHANGE, Page 13, 1977].

and oxygen tensions in the alveoli and capillaries have reached equilibrium. Each gram of hemoglobin is capable of carrying 1.39 cc oxygen when fully saturated. In normal individuals with 15 g of hemoglobin the total oxygen content of arterial blood is about 20 cc per 100 ml of blood. Only 0.3 cc of oxygen is physically dissolved in each 100 ml of blood when the arterial PO_2 is 100 torr.

Hemoglobin saturation is calculated from the oxyhemoglobin dissociation curve. At arterial oxygen tensions ranging from 60 to 100 torr the dissociation curve is relatively flat with hemoglobin saturation changing only 8% (90% to 98%). (Figure 5) Arterial oxygen tensions below 60 torr are not normally encountered during life, except at high altitudes and in disease. In systemic capillaries where oxygen tensions are as low as 35 to 40 torr, the hemoglobin dissociation curve becomes quite steep, and oxygen is readily released from the red blood cells. Changes in pH, PCO_2 , and temperature all favor the release of oxygen from hemoglobin

in the tissues and increase oxygen uptake by the red blood cells in the lungs.

The slope of the hemoglobin dissociation curve can be calculated and is conventionally expressed as the P_{50} . The P_{50} is the oxygen tension at which hemoglobin is 50% saturated. Normally the P_{50} of human blood is approximately 28 torr. A reduction in P_{50} indicates an increased hemoglobin affinity for oxygen (shift of the hemoglobin dissociation curve to the left), while an increase in P_{50} indicates a reduced affinity for oxygen (shift of the hemoglobin dissociation curve to the right). Figure 6 demonstrates the calculated hemoglobin dissociation curve for a 23-year-old patient with erythrocytosis and a congenital leftward shift in the dissociation curve (P_{50} of 18 torr).

Although the arterial PO_2 is the most important blood gas indicator of oxygen transport, there are multiple factors that must be considered in the evaluation of tissue oxygen delivery.³ These include oxy-

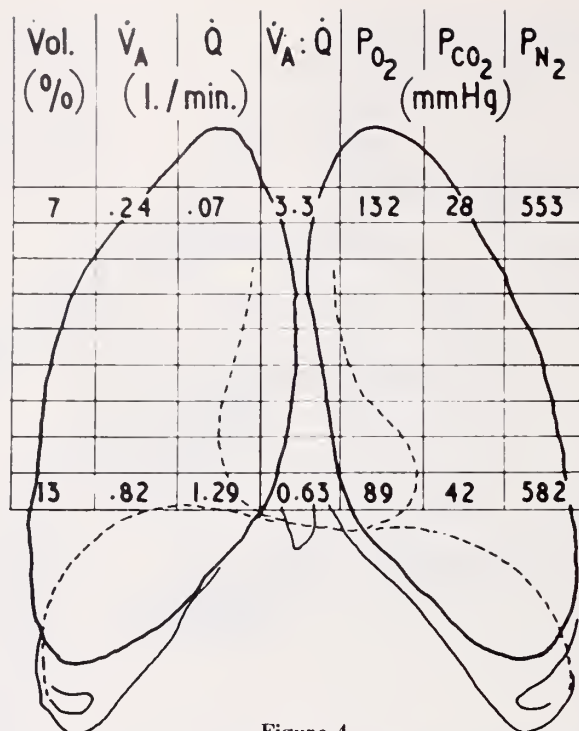


Figure 4
Distribution of ventilation and perfusion in the lung.
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FLOW AND GAS EXCHANGE, Page 40, 1977].

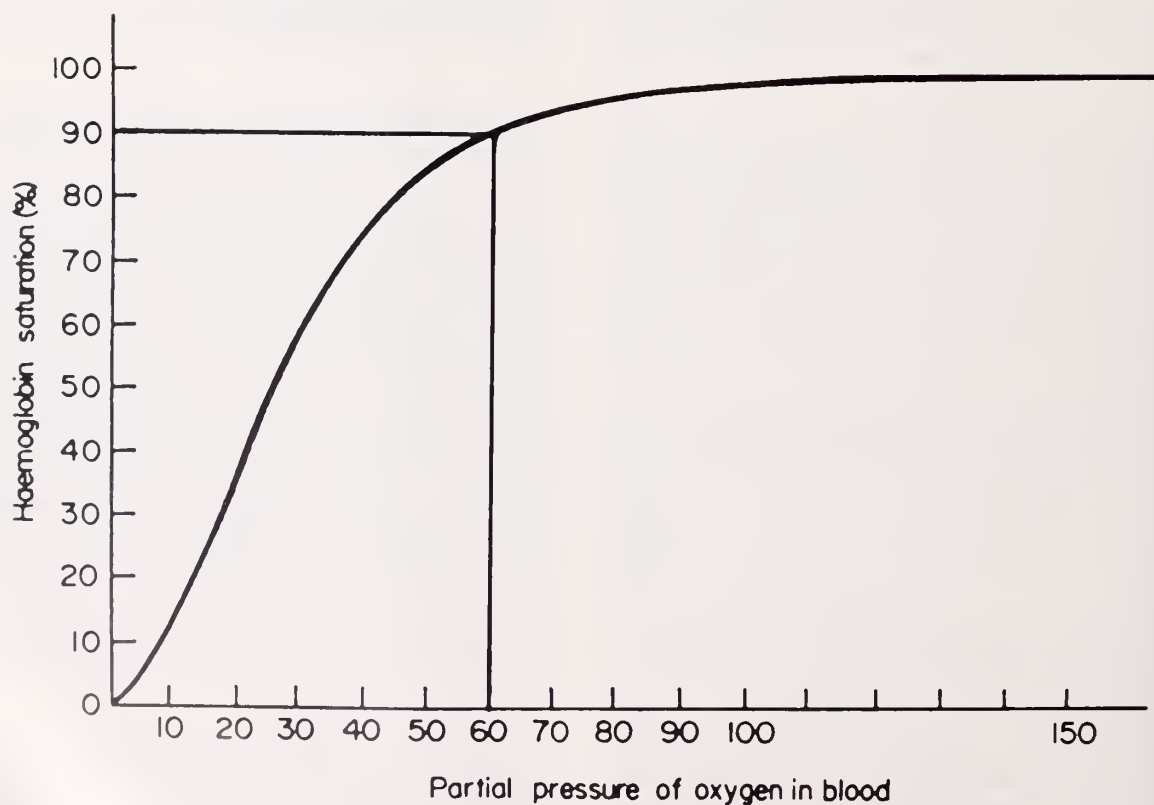


Figure 5
The hemoglobin-oxygen dissociation curve, demonstrating that 90 percent saturation has
been reached when the P_{aO_2} is 60 torr.

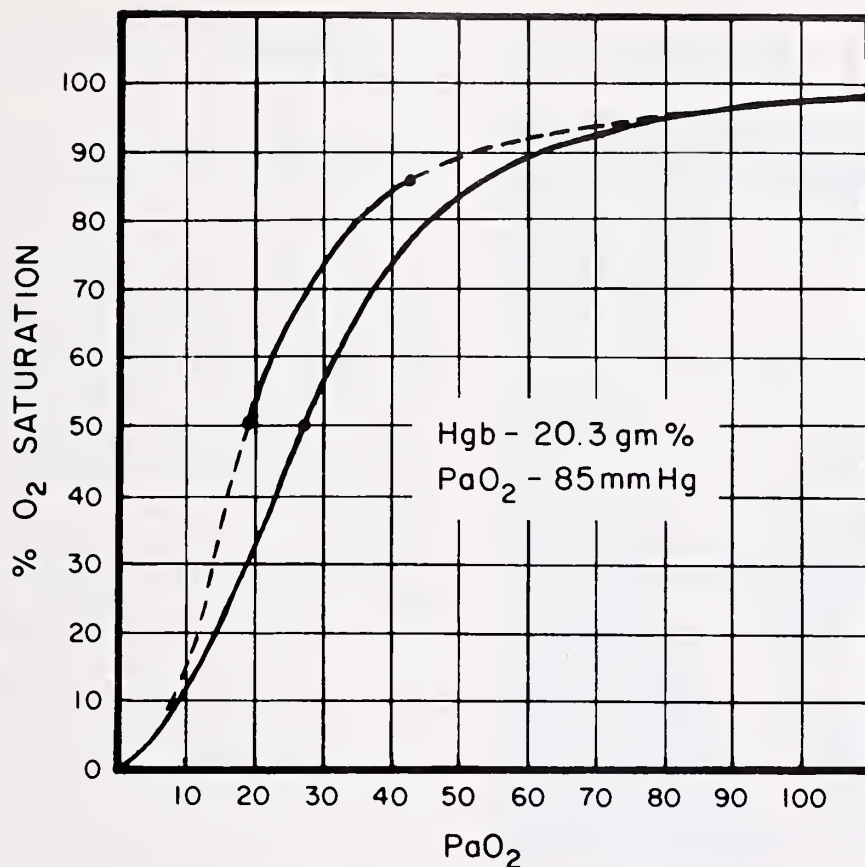


Figure 6

A calculated hemoglobin-oxygen dissociation curve [broken lines] for a patient with erythrocytosis and a

congenital shift to the left. [Normal curve presented as a solid line.]

gen utilization by the tissues, cardiac output, and arterial oxygen content.

Factors Influencing Oxygen Transport

1. Arterial Oxygen Content
 - a. Hemoglobin
 - b. Dissociation Curve
 - c. PaO₂
2. Tissue Perfusion
 - a. Cardiac Output
 - b. Local Circulation
3. Tissue O₂ Consumption
 - a. Metabolic Activity
 - b. Oxidase System

Completely normal arterial blood gas values may be associated with severe tissue

hypoxia when there is marked anemia, leftward shift of the hemoglobin dissociation curve, reduced cardiac output or impaired circulation. In fact, small changes occurring simultaneously in several of these areas can result in marked reduction in oxygen transport.

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Down Memory Lane

1. When a bowel obstruction looks sick, he is sure to die.

2. No field of education has made greater advance in the past twenty-five years than that of medicine.

3. Direct laryngoscopy revealed a markedly swollen larynx with a fragment of egg shell between and beneath the vocal cords. The egg shell was removed and intubation by the direct method immediately after the laryngoscopy, was performed. The tube was removed on the fourth day.

4. Drunkenness is pathology, mental or physical.

5. Insulin has almost wiped out coma.

6. All ponderable matter emits radiant energy.

7. The A.M.A. now has 94,000 members.

8. Typhlites should refer to the changes taken place in the head of the caecum and surrounding peritoneal coverings and to chronic disease of appendicial origin.

9. Acute biliary disease severe enough to demand operation in the primary attack is rare, though occasionally it may be encountered.

10. The perforation of gastric or duodenal ulcers is preventable in the large majority of cases.

Nebraska State Medical Journal
July, 1928.

President's Page

Today's modern physician attracts more criticism than his horse and buggy grandfather. The impressive contributions of the contemporary physician to the decline of numerous diseases is taken for granted as is this age of space flights and satellite communications. Grandfather could do little more than lend his physical presence and concern over the bed of a scarlet fever victim and he was considered a folk hero. His general practitioner grandson who undramatically stops a "beta strep" infection with a quiet course of penicillin is emerging as a twentieth century folk villain. The old family doctor, of course, is a myth of false imagery. He only had calomel, bitters, multicolored pills, and little to offer except the art.

It is difficult to see clearly why one hard working professional group has been singled out for such severe criticism as we have been subjected to. I do not believe that the cost of medical care is a reason because there's been a corresponding increase in legal fees and indeed the cost of everything else one needs or wants. Americans have long had a rather unique ingredient which is the capacity for self blame.

We knock our culture, deplore our politics, apologize for our laboriously wrought technology, we masochistically accept blame for whatever we do in the world such as 1) intervening overseas, and 2) for not intervening overseas.

So back to the scrutiny of the modern physician. The body of scientific data that he must absorb and digest from undergraduate school onward is so vast and the need for graduating new physicians so great that there is no time for him to acquire a general humanistic education unless he is a most remarkable person, he is forced by circumstance to treat humans without deep knowledge of humanity.

Consequently, the modern physician is too frequently an individual who has spent a great deal of time and effort obtaining his education, and works twice the number of hours of most other people and feels that he is entitled to live well materially. The



physician is vulnerably from attacks from ideologists, (everyone who is not a physician) for that selfishness. He is under indictment for practicing a discipline that is unfor- givingly almost as much an art as a science. He has no protection from patients, who by virtue of Reader's Digest and other similar medical publications, have become his peers. And often he has not truly come to grips with his own American cultural hangups of inferiority and guilt.

But whatever he may lack of the philosophy and literature, he is undeniably the best equipped medically, best educated physician in the world. He outstrips his late and fabled grandfather in every pertinent area. He knows more, has superb diagnostic paraphernalia with ready access to a gigantic pharmaceutical arsenal, has the capability for immediate communication with experts in any location and in any medical subspecialty and has access to the knowledge contained in journals and computers from everywhere.

The common American is today enlightened and educated to the degree unknown throughout history. Even our major religions are practiced differently and thought of differently than in the past. It would take a miracle for us to recognize a miracle today. Faith healing, the laying on of hands, vegetarianism to purge the evils from us, exorcism resurrected from the distant past, acupuncture, all of the ancient and discarded therapeutics of fright are resurging with a vengeance. "We look for the secrets of people who have lived to be centenarians or more and we deposit our aged in vast nursing homes." So this does not seem to be a very rational age.

The lay populous no longer seems to see the mission of the medical practitioners to be the alleviation of pain and suffering and the curing of curable diseases. The physician must save lives and we cannot forgive them for not being able to satisfy that demand. Every physician has heard the complaint that "after all of the tests and after all of the medicines in the hospitals and the money down the drain, my mother, sister, wife died anyway." It would seem that the physicians are not the only Americans who lack philosophical backgrounds.

The physician does fight death with every weapon in his arsenal but "nobody makes it through life alive." He, the physician, always loses in the end. It is the duration and the quality of the battle even if that is within his scope of control that makes a good or bad physician. As the people clamor for magicians and holy men of medicine, the Congress is stripping away what little mysticism remains by legislating for full disclosure. This is all right for an enlightened people but many of us are so suggestible that to hear the possible side effect will be to increase our chance of developing them or worse we may be frightened enough to refuse appropriate therapy.

How then can the American physician improve his image? It has been suggested that perhaps a priesthood of physicians

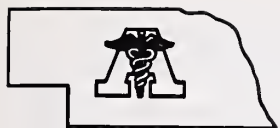
complete with rope-belted brown robes, sandals, vows of poverty, chastity, and abstinence with prescriptions written in sanskrit and with the black art mixed with the white would be helpful. And if Congress continued to insist on passing laws for people-as-they-should-be instead of for people as they are, the physician could conjure a pox on both of their houses.

Today's physician should indeed try to develop more depth and philosophy. If there is time for golf and fishing, there is time for reading that could help him understand people as well as diseases. The two are indistinguishable; the people have the disease and the diseases have the people.

The faults of the honest physician are easily corrected. He really does know that his time is no more valuable than that of his patients, he can easily stop the prolonged wait of patients to see his "magnificence." He can limit the number of patients he sees so that he can give them his full attention when they finally make it to the intersanctum. So physicians should try to correct their faults and medical students should avoid acquiring them, but at the same time the physician should try to correct the false concept about medicine that exists among the populous. Most importantly to both patient and doctor let it be made plain that no one can "save lives." How can we hope to isolate one profession for purification when all are contaminated? It is a bitter draught to go down-to be singled out for peer review, when government and law are so much more in need of reform than medicine. Both lives and freedom are lost because of their "mal-practicing," but both groups have the benefit of being once removed from life and death situations. They have an anonymity which doctors lack.

The doctors, poor things, are dealing on a one to one basis with life and death. The physicians did not create the problem but they must have the solution or the government will simply march off without us.

Houtz Steenburg, M.D.



The Auxiliary

On February 18, 1978, Mark, age six and his sister Lisa, age five escorted their mother, now long overdue for a refresher course in anatomy and physiology, as we embarked on the "Health Sciences and You" program at the State Museum. Elephant Hall has become a favorite haunt for our family; we scanned, once again, those familiar exhibits — fossils and furry faces inimitable by even Walt Disney, as we made our way to the orientation classroom. This was the first of five class sessions and as such afforded us the introduction to the format and course objectives set to achieve our mutual goal — the optimum care of our bodies.

The class attendance was composed of thirty-five alert, eager, eight-to-eleven-year olds, the majority of whom had background in physiology which harkened much more than a mere elementary understanding of body systems, as well as Mark and Lisa who had been invited to audit the course for initial reaction and feedback. Many of the youngsters were involved in or familiar with C.P.R.

The course instructor, Dr. Kerry Redican, assisted by members of the Health Education Department, including Dr. Ian Newman, distributed a feedback questionnaire to provide them a better understanding of students' background in health education, as well as individual suggestions for course content. The course overview was presented as a series of sessions which would offer us information geared to help us make positive decisions relating to our bodies and the maintenance of good health. "Adaptation" — a quality of ongoing life on earth was discussed by the class. It was an exchange of statements far more serious than a simple

transition from 'dinosaurs-to-discos.' Subsequent sessions in comparative anatomy using dissecting technique were proposed. Also, a notebook would be planned and assembled by each student and then used as a follow-through study at home.

We discussed the nine body systems. This discussion delighted the class, who participated as informed contributors. I was particularly impressed with not only the accuracy of definition, but also the remarkably clear understanding of system function. These elementary school students then viewed CERES on the adult tape, after which they enjoyed a brief review of systems and specific organs. We viewed a short film entitled "Take Joy," a positive reinforcement of the responsibilities of self-health care.

The session culminated with sub-groups of three or four outlining one of their member's body on an appropriately large piece of paper. What followed was an art festival of diligent, accurate positioning of body organs and systems in full, living, wall-to-wall crayola color! Mark and Lisa presented me with a keen picture of a tri-lobed brain detailed with a happy face and somewhat asymmetrical ears!

We were happy to participate in this first program, are grateful to the Health Education Department, and will hope to return to find it continuing in the classroom in the Health Galleries. It is a positive, constructive resource unit and certainly offers an active, participating role for the students as they investigate and learn about the human body. It is a program format which reinforces with review and laboratory experience to provide essential information used in developing habits and skills which promote positive self-health maintenance.

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Total cost of the Health Galleries Project - \$500,000.00
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*House of Delegate action October 1976, recommended
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70% of the \$150,000.00 has been raised
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Our Medical Schools

Commencement at U of N.

Chancellor Neal A. Vanselow conferred 449 degrees at the University of Nebraska Medical Center's commencement ceremonies Sunday, May 21, at 2:30 p.m. in the Omaha Civic Auditorium.

Those degrees being conferred include: four doctor of philosophy, four master of science, 12 master of science in nursing, 32 bachelor of science in nursing, 95 associate of science in nursing, 110 doctor of medicine, 22 bachelor of science in medicine, 70 bachelor of science in pharmacy.

Forty-six bachelor of science in medical technology, 16 bachelor of science in physical therapy, 23 bachelor of science in the physician's assistant program, one bachelor of science in radiologic technology, eight associate of science in radiologic technology and six associate of science in nuclear medicine.

Of the 110 receiving doctor of medicine degrees, 42 will take residencies at University of Nebraska affiliated hospitals.

Distinguished Service to Medicine Award to Dr. Cole.

The University of Nebraska Medical Center presented its Distinguished Services to Medicine Award to Dr. Frank Cole, Editor of the Nebraska Medical Journal, during commencement ceremonies Sunday, May 21, at the Omaha Civic Auditorium.

Dr. Cole has edited the Journal since 1965, during which time he has provided Nebraska physicians with a vehicle for sharing medical information and advancing scholarly writing.

After receiving his M.D. degree from Long Island University, he completed an internship at Green Point Hospital in Brooklyn, N.Y. and took a residency in anesthesiology at the University of Minnesota.

After two years on the faculty of Minneapolis Hospital, Dr. Cole became Director of

anesthesiology at St. Mary's Hospital in Duluth.

He is currently a senior consultant in anesthesiology at the Veteran's Administration Hospital in Lincoln and a clinical associate in anesthesiology for the College of Medicine.

Mrs. Meyer honored.

A major donor to the C. Louis Meyer Children's Rehabilitation Institute received the Chancellor's Distinguished Service Citation from the University of Nebraska Medical Center Sunday, May 21, during commencement ceremonies at the Omaha Civic Auditorium.

Mrs. C. Louis Meyer's gift of \$350,000 in 1958 made possible the construction of the institute which is named in honor of her late husband, the founder and president of the Ceco Corporation.

Since then the institute has been better able to serve handicapped children and their families throughout the state because of Mrs. Meyer's continued support.

In 1972 she provided another \$175,000 to the institute for the addition of the Mary Luman Meyer Wing and in 1976 she established the Mary Elaine Meyer O'Neal Award Lecture in Developmental Pediatrics. She has also supported the C. Louis Meyer Professorship in Child Health since 1967.

Her educational and health interests are further exemplified through her support of the Sandhill Community College and the Moore Memorial Hospital in Pinehurst, N.C. and her establishment of the Abner Luman Library at the University of Wyoming in memory of her father.

A native of Rock Springs, Wyo. and long-time resident of Salt Lake City, Mrs. Meyer took her education at Utah's Roland Hall, the National Park Seminary in Washington, D.C. and the University of Utah.

Mrs. Meyer moved to Omaha after her marriage and then to Lake Forest, Ill. when

her husband moved the Ceco Corporation to Chicago.

Mrs. Meyer has served as president of the Junior league of Omaha and was on the national board of the Junior Leagues of America.

Creighton honors.

A testimonial dinner honoring a prominent Lincoln, Nebraska surgeon was held at the Omaha Club on Wednesday evening, May 17.

Scheduled in conjunction with the department of surgery's Seventh Annual Surgical Post-Graduate Course at the Creighton University School of Medicine, the dinner honored Roland F. Mueller, M.D., a member of Creighton's faculty since 1948. Dr. Mueller was recognized as the department of surgery's outstanding educator and surgeon for 1978.

Dr. Mueller holds a doctor of medicine degree from Washington University and, in 1939, was one of the first 100 surgeons certified by the American Board of Surgery. Dr. Mueller has been a practicing surgeon in Lincoln since 1947 and has served as president of the Lancaster County Medical Society and served as chairman of St. Elizabeth's Hospital Department of Surgery for twelve years.

Receiving recognition as the outstanding senior medical student in the department was Maryanne Dokler of Fairview Park, Ohio. Ms. Dokler received a doctor of medicine degree at Creighton's commencement exercise on Saturday, May 20, and will enter Creighton's post-graduate training program in surgery.

Award to Max C. Coppom.

The first annual Jack G. Elliott Award was given to Max C. Coppom at the University of Nebraska Medical Center's commencement ceremonies Sunday, May 21, at the Omaha Civic Auditorium.

In receiving the award, which was established in memory of a former University of Nebraska regent, the president of Scottsbluff's Western Nebraska General Hospital was

cited for his accomplishments in health planning in the Nebraska Panhandle and strengthening the image of UNMC in that area.

Since assuming his post in 1954, Coppom has been a leader in health affairs both regionally and statewide.

Coppom is president of the Panhandle Health Growth Services, treasurer of the Panhandle Memorial Cancer Fund, secretary-treasurer of the Panhandle Memorial Cancer Fund, secretary-treasurer of the West Nebraska General Hospital Foundation and a Nebraska regent for the American College of Hospital Administrators.

In serving on the university's Rural Health Task Force, Coppom helped shape and implement several key recommendations. He was also instrumental in arranging sites in greater Nebraska where the University of Nebraska College of Nursing could offer courses leading to a baccalaureate degree for western Nebraska registered nurses.

A graduate of the University of Denver, Coppom has served as president of the Nebraska Hospital Association and Region 22 of the Health Planning Council.

Coppom, who was the 1967 recipient of Nebraska Wesleyan University's Distinguished Citizen Award, has also been recognized for his civic leadership. He is vice-chairman of the Scottsbluff Planning Commission and president-elect of the Scottsbluff Rotary Club. He also served as president of the Scottsbluff Chamber of Commerce.

Honorary degree to Joseph D. Williams.

A native Nebraskan who has scaled the ladder of professional achievement received an honorary Doctor of Pharmacy degree at the University of Nebraska Medical Center's commencement ceremonies Sunday, May 21, at the Omaha Civic Auditorium.

Joseph D. Williams, senior executive vice-president and president of the international group of Warner-Lambert Company, helped insure the educational excellence of the College of Pharmacy by being the 1975 chairman of its program Development Fund.

As president of the drug manufacturing firm of Parke, Davis & Company from 1973 to 1976, Williams was instrumental in establishing the Michigan Pharmaceutical Association-Michigan Pharmacy Manufacturers Relations Committee, which brought together pharmaceutical executives and practicing pharmacists to discuss solutions to mutual problems.

As a result of this, the Pharmaceutical Manufacturers Association Pharmacy Liaison Committee was formed to bring harmony to the drug delivery system throughout the country.

Williams, whose father and grandfather

operated a pharmacy in Pawnee City, joined Parke-Davis as a Nebraska field representative after graduating from the College of Pharmacy in 1950.

Williams held a variety of executive positions with Parke-Davis and its parent company, Warner-Lambert, before assuming his current responsibilities.

Williams has also served as director and chairman for several professional organizations, including the Medical-Surgical Manufacturers Association, the Health Industries Manufacturers Association and the Device and Diagnostics Section of the Pharmaceutical Manufacturers Association.

Physicians' Classified

Advertisements in this column are run at a rate of twenty cents per word with a minimum of \$10.00 per insertion. Copy must be received by the fifth of the month preceding date of publication and should not exceed 50 words. Each advertisement will be taken out following its first appearance unless otherwise instructed. Where numbers follow advertisements, replies should be addressed in care of The Nebraska Medical Journal, 1902 First National Bank Building, Lincoln, Nebraska 68508.

FOR SALE: Picker X-ray machine \$6,000, excellent condition. Today's replacement value is \$20,000. If interested, contact Dr. Latenser (402) 558-0990 collect, 809 The Doctors Building, Omaha, NE 68131.

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7-78

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Picture Gallery

NMA 1978 Annual Session



Doctors James E. Ramsay, Houtz G. Steenburg and Arnold W. Lempka.



Doctor Carlyle E. Wilson, Jr. presiding at Board of Councilors session.



Board of Councilors session.



Fifty-year practitioner, Doctor Roy S. Cram, and guests.



Doctor Edward A. Holyoke, Jr. presiding at Annual Recognition and Religion Banquet.



Fifty-year practitioner, Doctor John R. Schenken, and guests.



Doctor and Mrs. Arnold W. Lempka, Father Clifford Stevens, Doctor and Mrs. Edward A. Holyoke, Jr. and Doctor and Mrs. Houtz G. Steenburg.



Fifty-year practitioner, Doctor Olin J. Cameron, and wife/Fifty-year practitioner, Doctor John M. Christlieb, and wife.

Picture Gallery

NMA 1978 Annual Session



Doctor Arnold W. Lempka introducing Annual Recognition and Religion Banquet speaker.



House of Delegates session.



Father Clifford Stevens speaking at Annual Recognition and Religion Banquet.



House of Delegates session.



Nebraska Dental Association representative, J. G. Morgan, D.D.S., addressing House of Delegates.



Doctor James H. Dunlap presenting Reference Committee report.



University of Nebraska College of Medicine Chancellor, Doctor Neal A. Vanselow, addressing House of Delegates.



Doctor Charles W. Landgraf, Jr. presiding at House of Delegates session.

Between Cases

How Are You?

I inhabit a weak, frail, decayed tenement,
battered by the winds, and broken in
upon by the storms, and from all I can
learn, the landlord does not intend to
repair.

J. Q. Adams

Section On Malpractice.

If you had something wrong with you, and
if you went to see a number of doctors
about it, then picked the one you agreed
with, wouldn't the treatment you re-
ceived be as much your responsibility as
the doctor's?

From The doctor game,
by Howard A. Olgin, M.D.

Department Of Admissions.

Since the patient was in no acute distress,
he was admitted for work-up.

The History.

Q: Where did you get these eyeglasses?

A: Last year.

Where did you get the hearing aid?

The Chief Complaint.

Individual's complaint: many.

Words We Can Do Without.

Do (we do have, he did do), reprise, retro-
spective, conceptualize, structured, dis-
interested.

O To Be In England.

It is impossible for drivers to keep their
timetable if they have to stop for
passengers.

Sign on a bus.

Section On Eye And Ear.

Diagnosis: otitis externa, right eye.

Section On Sections.

82 specialties are now recognized.

The Pool.

Dictated: IV disk.

Typed: Fourth disk.

IV = 4, I guess.

Quote Unquote.

He observed more people died of grief
than of any other disease.

Anon; said of Doctor William Harvey.

Section On Accidents.

The author was accidentally bitten while
milking a carpet viper.

I think the snake did it on purpose.

Section On Therapy.

Drugs are not always necessary. Belief in
recovery always is.

N. Cousins

Quote Unquote.

In poverty I lack but other things; in
banishment I lack other men; but in
sickness I lack myself.

John Donne.

—F.C.

The Letter Box

June 5, 1978

Frank Cole, M.D.
13 Bishop Square
Lincoln, Nebraska 68502

Dear Dr. Cole:

Congratulations on your Distinguished Service to Medicine Award. It certainly went to a deserving person.

We are publishing the announcement.

Cordially,
Larry Boston
Editor
American Medical News

Dear Dr. Cole,

The Nebraska Medical Association Auxiliary wishes to thank you for your help this past year in putting items of interest to us in the Nebraska Medical Journal, and for your support of our newsletter.

Sincerely,
Gloria Snyder
Corresponding Secretary

Dear Editor,

As a student delegate, I would like to express a hearty thanks to the Nebraska Medical Association for sponsoring my attendance at the 110th Annual Session.

The meeting was a great balance of business, medical science, and relaxation. Guest speakers and scientific sessions were very stimulating and the House of Delegates was a good learning experience, as well as an introduction to the social, political, and economical aspects of medicine that medical students are often sheltered from.

At the conclusion of the three days I was impressed with the content of thought demonstrated at the meeting and the friendliness of the members.

Again, I offer my appreciation to the Association and remain,

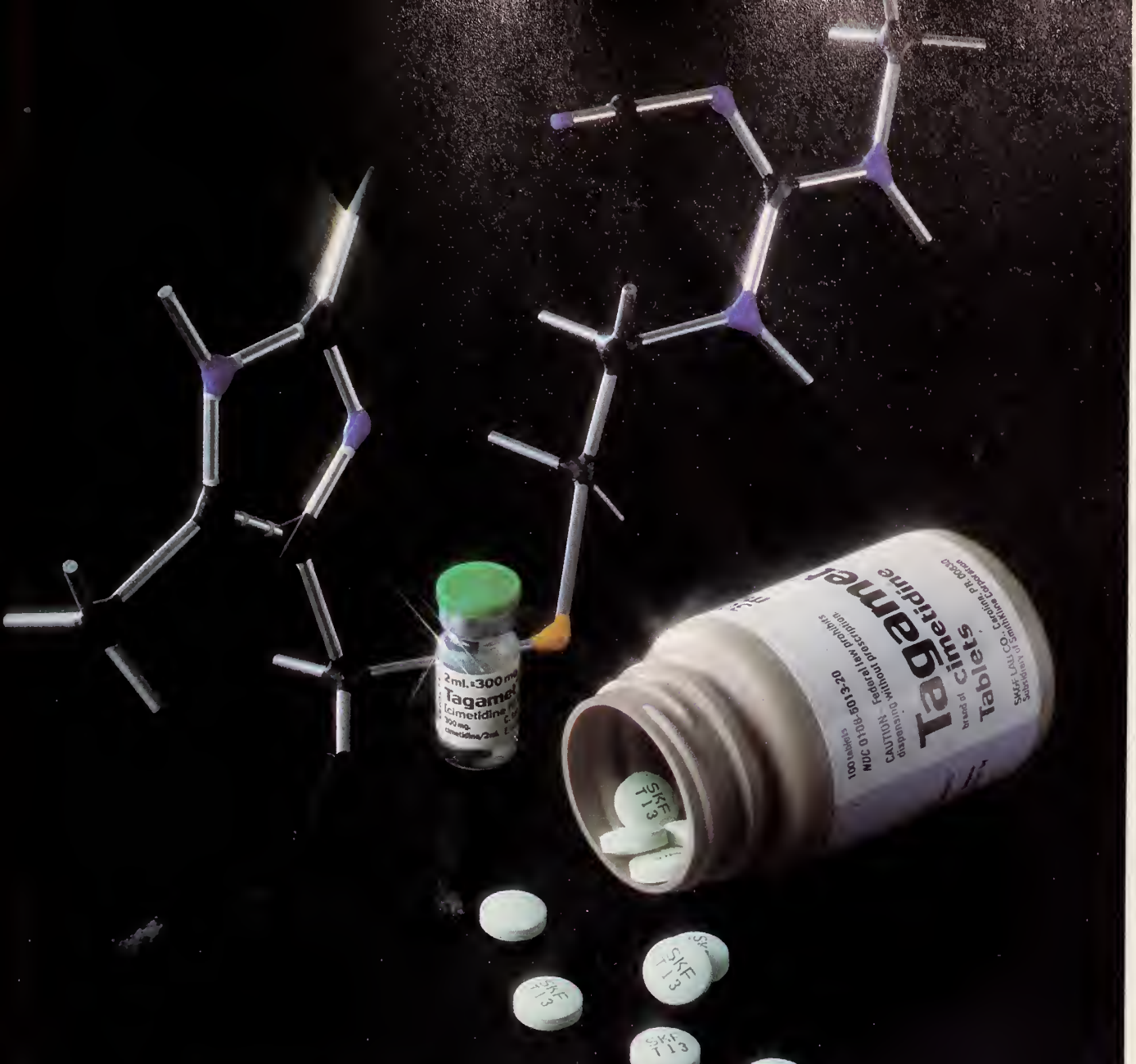
Respectfully yours,
Mark C. Wilson
University of Nebraska Medical Center
College of Medicine

To the Editor:

For your information James H. Rickman, M.D., Lincoln, Nebraska was elected Councillor for the State of Nebraska for the Southwestern Surgical Congress. Vice Councillors appointed for the state are:

William T. Griffin, M.D., Lincoln
James F. Kennedy, M.D., Alliance
Merle M. Musselman, M.D., Omaha
Claude H. Organ, Jr., M.D., Omaha

Jack A. Barney, M.D.
Secretary-Treasurer



Tagamet[®]

brand of

cimetidine

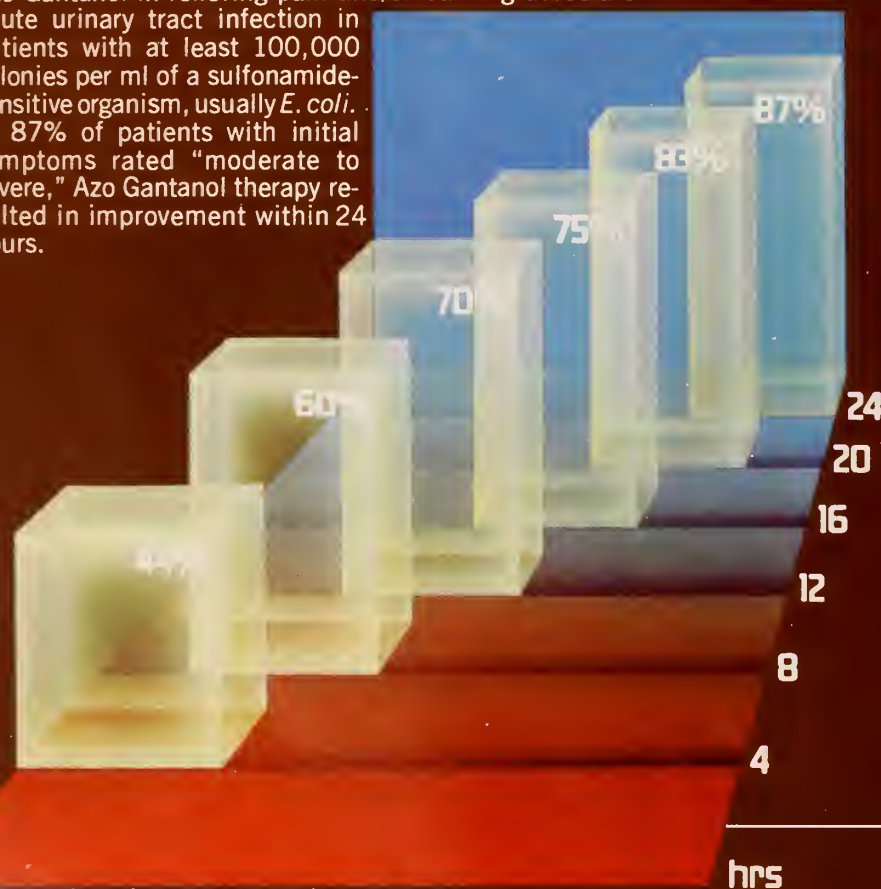
Now Supplied: Pale green, 300 mg. tablets in bottles of 100 and Single Unit Packages of 10 (intended for institutional use only).
Injection, 300 mg./2 ml., in single-dose vials in packages of 10.

SK&F LAB CO.
SmithKline company

Important data on the pain of acute cystitis:

In 87% of patients studied (303 of 349), Azo Gantanol® reduced pain and/or burning within 24 hours*

A controlled, multicenter study assessed the efficacy of Azo Gantanol in relieving pain and/or burning associated with acute urinary tract infection in patients with at least 100,000 colonies per ml of a sulfonamide-sensitive organism, usually *E. coli*. In 87% of patients with initial symptoms rated "moderate to severe," Azo Gantanol therapy resulted in improvement within 24 hours.



Fast pain relief plus effective antibacterial action

Azo Gantanol®

Each tablet contains 500 mg sulfamethoxazole and 100 mg phenazopyridine HCl.

For the pain For the pathogens

*Data from Hoffmann-La Roche, New Jersey 07110.

Before prescribing, please consult complete information, a summary of which follows. **Indications:** In adults, urinary tract infection complicated by pain (primarily pyelonephritis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Not fully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response.** aminobenzoic acid to follow-up culture may indicate increasing frequency of resistant organisms. **the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels; variations may occur; 20 mg/100 ml should be the maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term or during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatic uremia, and pyelonephritis of pregnancy with disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, aplastic anemia, and other blood dyscrasias have been reported and early clinical signs (throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent urinalysis with microscopic examination is recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, thrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolytic urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, sensitization, arthralgia and allergic myositis); *G.I. reactions* (nausea, emesis, abdominal pain, hepatitis, diarrhea, anorexia, pancreatitis, stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, nephrosis with oliguria and anuria, perianth nodosa and L. E. phenomenon). Due to chemical similarities with some goitrogenic agents (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the painful phase of urinary tract infections. **Adult dosage:** 2 Gm (4 tabs) initially, then 2 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists after relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the dye (phenazopyridine HCl) will color the urine. **Supplied:** Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

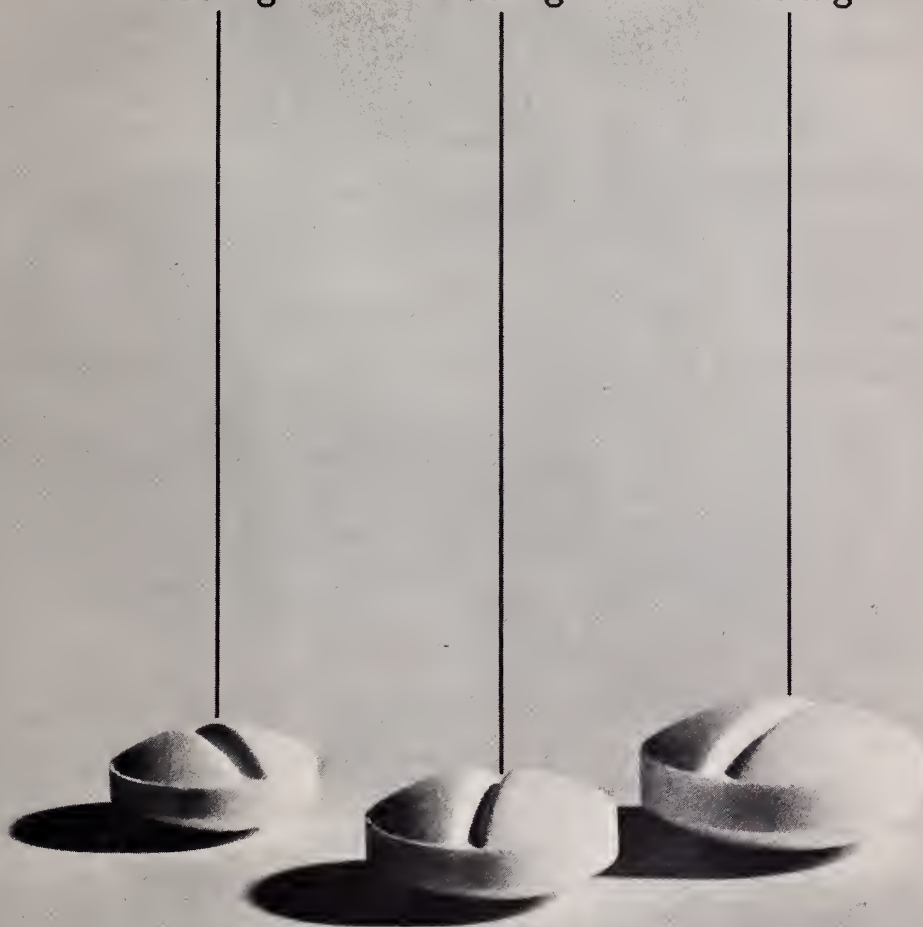


Roche Laboratories
Division of Hoffmann-La Roche
Nutley, New Jersey 07110

100 mg

250 mg

500 mg



Tolinase[®]

tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-G

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EMPIRIN COMPOUND c CODEINE

Each tablet contains aspirin, 227 mg; phenacetin, 163 mg; and acetaminophen, 32 mg; plus codeine phosphate in one of the following strengths: #4—60 mg (gr 1), #3—30 mg (gr 1/2), #2—15 mg (gr 1/4), and #1—7.5 mg (gr 1/8). (Warning—may be habit forming)



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Coming Meetings

CRIPPLED CHILDREN'S CLINICS —

July 8 — Chadron, Elks Lodge
July 29 — Norfolk, Elks Lodge
August 12 — Scottsbluff, St. Mary's
Hospital
August 26 — McCook, Elks Lodge

NEBRASKA MEDICAL ASSOCIATION —

Fall Session, September 22-24, 1978, Lincoln Hilton Hotel, Lincoln, Nebraska.

OMAHA MID-WEST CLINICAL SOCIETY:

46th Annual Postgraduate Assembly; Omaha Hilton Hotel; October 30, 31 and November 1, 1978. Write to: Lorraine E. Seibel, Executive Secretary, Omaha Mid-West Clinical Society, 540 Medical Arts Building, Omaha, Nebraska 68102.

AMERICAN MEDICAL ASSOCIATION —

Interim Session, House of Delegates, December 2-6, 1978, Palmer House, Chicago, Illinois.

AMERICAN MEDICAL ASSOCIATION —

Winter Scientific Program, December 7-10, 1978, Las Vegas, Nevada.

NEBRASKA MEDICAL ASSOCIATION —

Annual Session, April 29 - May 2, 1979, Holiday Inn, Kearney, Nebraska.

AMERICAN MEDICAL ASSOCIATION —

Annual Convention, July 22-26, 1979, Chicago, Illinois.

Books



Review of medical microbiology; by Ernest Jawetz, Ph.D., M.D., Joseph L. Melnick, Ph.D., and Edward A. Adelberg, M.D.; 550 pages, limp cover \$12.00; published 1978 by Lange Medical Publications, Los Altos, California 94022.

This book first appeared in 1954, and is now in its 13th edition. It has been translated into Spanish, German, French, Italian, Portuguese, Turkish, Serbo-Croatian, Japanese, and Polish. The authors (there are two more, in the section on medical parasitology, and they are from California) are from San Francisco, Houston, and New Haven.

There are no less than 41 chapters, there is a good index, there are many figures and unnumbered references, and the print is good so that reading is easy. The 12th edition appeared in 1976, so this one is obviously up-to-date.

It is a better buy than dinner-for-two, and it doesn't cost as much. I like it.

—F.C.

The doctor game; by Howard A. Olgin; 296 pages; hard cover \$8.95; published 1978 by J. B. Lippincott Company, Philadelphia and New York.

The book is fiction and is all about doctors' fallibility and greed and callousness. It is concerned mostly with one case: a surgeon operates for cancer and cancer is not found, and the patient dies.

The case report is interesting; the mortality and morbidity conference is lively, but too lively; there is more than I like of personal events.

But what completely spoiled the book for me was the insistence on the repeated use of dirty words. There are too many of them and I found their appearances offensive and inexcusable. As Ibsen nearly said, people don't say these things. The stooping to obscenity robs the text of whatever chance it had of being called good writing.

The author is an M.D. The medical considerations are interesting, but I will not recommend the book.

—F.C.

Medicine

Dr. Starke honored.

Dr. Helen Starke received the University of Nebraska College of Medicine's 1978 Distinguished Teacher Award at the college's honors convocation Saturday, May 20, at 7:30 p.m. in the Hilton Hotel Grand Ballroom.

Dr. Starke, an associate professor of internal medicine, was chosen for the \$1,000 award, which also consists of a plaque, on the basis of student, faculty and house officer voting.

Before coming to the Medical Center as an assistant professor in 1969, Dr. Starke was an instructor in medicine at the University of Kansas for two years.

She also taught at Columbia University and Duke University School of Medicine, of which she is a 1942 graduate.

Dr. Starke is a fellow in the American College of Physicians and an associate fellow in the American College of Cardiology.

Dr. Swanson honored.

The University of Nebraska Medical Center awarded an honorary Doctor of Science degree to Dr. August George Swanson at commencement ceremonies Sunday, May 21, at the Omaha Civic Auditorium.

Dr. Swanson's role as director of academic affairs for the Association of American Medical Colleges has been an important extension of his scholarly commitment to maintain and advance national medical academic standards.

A 1949 graduate of Harvard Medical School, Dr. Swanson has worked in a variety of health care and administrative capacities.

After several residencies and neurology fellowships in Seattle, Boston and Oxford, England, Dr. Swanson became an instructor in medicine and pediatrics at the University of Washington in Seattle and co-director of the neurology educational programs at Childrens Orthopedic Hospital and Medical Center in 1958.

In 1964 he was appointed chief of neurology service for Seattle's Harborview Medical Center and University Hospital. He was also head of the University of Washington School of Medicine's Division of Neurology and a neurology consultant to several Washington hospitals.

The Kearney native was also associate dean for academic and student affairs for the University of Washington School of Medicine between 1967 and 1971, during which time he served briefly as acting dean.

An author and co-author of 37 scientific papers, Dr. Swanson has been a member of the Robert Wood Johnson Foundation Advisory Committee, the National Heart and Lung Institute and the National Center for Health Services Research.

He is a Markle scholar in medicine.

Variety Club sponsors program.

1978 will be remembered as a special one for the University of Nebraska Medical Center Meyer Children's Rehabilitation Institute.

Not only is the institute celebrating 10 years of service to the university and 20 years of service to the state, but its anniversaries will be marked by an 18-½ hour telethon, which will be sponsored by the Variety Club of Omaha and aired June 10 and 11 on WOWT-Channel 6.

The purpose of the telethon will be to raise part of the \$1 million the institute needs annually in addition to state funds to maintain what has been its major focus since the institute's 1968 affiliation with the university — treatment programs for children with handicaps.

Even before its decade-long relationship with the Medical Center, the institute fulfilled an important role in caring for children with handicapping conditions. When it was established in 1958 as the Meyer Therapy Center with a \$380,000 gift from the C. Louis

Meyer family, it served as a treatment facility for children affected by the polio epidemics of the 1950's, according to Dr. Paul Pearson, institute director.

As MCRI programs grew and other needs were realized in the first few years, available space at the institute became scarce. In 1972 with the financial aid of the Meyer family, the institute added the Mary Luman Meyer wing, which increased floor space by 8,000 square feet.

The institute realized another expansion this year when the board of directors for the adjacent Hattie B. Munroe Pavilion decided to lend support and provide space for a number of MCRI's programs.

The latest additions have not only helped make it possible for the institute to provide clinical education for 250 college students each year, but also to maintain its 16 services which are now being offered to over 1,000 handicapped children and their families annually.

Distinguished Service to Pharmacy Award to Leroy J. Schroeder.

The vice-president and general manager of Dorsey Laboratories, Lincoln, received the University of Nebraska Medical Center's Distinguished Service to Pharmacy Award during commencement ceremonies Sunday, May 21, at the Omaha Civic Auditorium.

The honor was bestowed upon Leroy J. Schroeder for his contributions to the College of Pharmacy's educational and research programs.

As chief executive officer of Dorsey Laboratories, Schroeder has been instrumental in supplying undergraduate and graduate pharmacy students with scientific talent and equipment, a form of education not otherwise available in the state.

The adequacy of the College of Pharmacy's physical plant for the research needs of faculty and students has been assured through Schroeder's role as co-chairman of the Nebraska Pharmacy Program Development Fund.

Schroeder has also been active in maintaining the competency of practicing pharmacists by providing support for an on-going continuing education program for the profession through the resources of the College of Pharmacy and Dorsey.

In addition to his Dorsey position, the former Fullerton High School teacher and coach serves in other capacities, including president of the Wander Foundation of Medical Research and a member of the Board of Directors for the Lincoln Chamber of Commerce, the First National Bank and Trust Company of Lincoln and the Lincoln Mutual Life Insurance Company.

He is also on the Board of Trustees for Bryan Memorial Hospital and the Board of Counselors of the Medical Center.

WashingtonNotes

Hospitals and costs.

The Health, Education and Welfare Department has asked the Justice Department to delay granting the nation's hospitals an exemption under the antitrust laws in order to carry out their voluntary cost containment effort.

HEW General Counsel wrote Justice that the Voluntary Effort might discriminate against small community hospitals and health maintenance organizations and also might work to hold down wages of hospital workers.

The vote on hospital controls in the House Commerce Committee is considered the key to the fate of the Administration's plan. President Carter has dispatched a letter to every member of the Committee urging them to back the Administration's plan.

Second opinion.

HEW is preparing to launch a program to encourage second opinions for surgery for Medicare/Medicaid patients. Patient pamphlets, physician enrollment, and radio-television ads are projected.

Public campaigns will begin soon and will consist of brief TV spot announcements and longer radio dramas and SO (second opinion) which will be distributed to stations. Five million leaflets will be distributed with Social Security checks in selected areas. A national "hot-line" (800 number) will be established, probably with the PSRO clearinghouse in Rockville, MD.

Once the program is operational, callers will be given the name of two or three physicians who are willing to accept requests for second opinion consultation. Wherever feasible, the referral center will try to give the names of physicians with some special competence in the type of condition for which surgery has been recommended, HEW said.

For Medicare patients, the program will pay for a second opinion as for other

consultations, at 80 percent of the reasonable charge, while Medicaid participation and payment, thus far, is at the option of the individual state. This may pose a tough problem in some states.

As presently planned, use of the "second opinion" will be at the patient's option, and the second opinion will not control payment for services.

Health planning.

Frank J. Jirka, Jr., M.D., Vice Chairman of the AMA Board of Trustees, told a National Journal Conference on Health Policy that the best way to uphold availability and quality is to have planning decisions made at the local level. Practicing physicians should be well represented on planning bodies, Dr. Jirka said.

Although the HEW Secretary has given assurances against the closing of existent hospitals, "they are not borne out in the body of the guidelines," Dr. Jirka noted. "Even the expansion of physicians' offices and their equipment would be affected if Congress decides to include them in the planning act's certificate-of-need provisions," he said.

Computers.

The AMA has cautioned against precipitous or unilateral government action in the field of computer technology for medical purposes. Such intrusion might retard the momentum developed with computers, the AMA told a House science subcommittee. H. Phillip Hampton, M.D., speaking for the Association, said "the primary thrust in the growing and changing field of computer technology has been and should remain in the private sector."

National health insurance (1).

The Chairman of the Council on Economic Advisors told the Administration that it is

"unrealistic at this time to propose a national health insurance (NHI) package which mandates universal and comprehensive low-dollar coverage."

In paper on NHI prepared for Presidential review, Charles Schultze said comprehensive coverage would stretch thin the health sector resources and thus exacerbate inflation. A sweeping NHI program would tend to override completely consumer latitude in choosing between health care and other goods and services such as housing and education, he said.

Enactment of a national health insurance (NHI) program with first rate mental health benefits may be the best, single step to help mentally ill Americans, according to the report of the President's Commission on Mental Health.

Declaring that one out of every seven suffers from some mental affliction, the Commission reported that too many of these are untreated. Almost half of the population could be classed as mentally ill or as experiencing severe emotional problems, the report said.

National health insurance (2).

A middle-of-the-road national health insurance bill with powerful Senate backing has been introduced into the Congress. Emphasis in the bill is placed on catastrophic coverage.

The measure is support by Chairman Russell Long (D-La) of the Senate Finance Committee, Health Subcommittee Chairman Herman Talmadge (D-Ga), and Sens. Abraham Ribicoff (D-Conn.) and Robert Dole (D-Kans.).

Health strategies.

In an unprecedented joint effort, Senator Edward Kennedy (D-Mass.) and the AMA will sponsor a two and a half day conference on Positive Health Strategies in Washington, D.C., July 25-27.

The sponsors have announced plans to bring together interested groups as co-sponsors and participants to focus public

attention on the potential benefits of strategies of **disease prevention** and to project possible programs for improvement in the 1980s.

The preliminary program lists keynote speakers as Senator Kennedy, Tom E. Nesbitt, M.D., President-Elect of the AMA, George Meany, President, AFL-CIO, and Lester Breslow, M.D., Dean, School of Public Health, University of California, Los Angeles.

In an address before the AMA's Leadership Conference in January of this year, Senator Kennedy issued an invitation to the AMA to join him in sponsoring a national disease prevention conference designed to focus the attention of the nation on the great potential of preventive measures to reduce the toll of disease in our population.

Dr. Nesbitt, in accepting for the AMA, stated, "we are happy to participate in an arena that encourages a wide spectrum of ideas and programs on health. Organized medicine and physicians have long been concerned with and active in the areas of disease prevention and positive health programs. We are certain that this interaction will be profitable to all Americans."

Lowell Steen, M.D., a member of the AMA Board of Trustees, said the AMA is basically supportive of the measure, formally called the National Disease Prevention and Health Promotion Act of 1978. Dr. Steen told a national television audience that some of the programs are "things that the AMA has been advocating for many years." However, we have "some reservations" about certain provisions, Dr. Steen said.

Health care costs & doctors' fees.

The White House Council on Wage and Price Stability plans an educational program for physicians on inflation in health care costs. The Council also will seek the assistance of the AMA in developing an effective monitoring or reporting mechanism to measure the rate of physicians' fees with respect to an agreed upon measuring device or indicator.

The objective is to develop a long-term

mechanism to assist in cutting the rate of increase in the future.

The plans were discussed with AMA officials at a recent Washington, D.C., meeting. Among those attending were John Budd, M.D., AMA President; Frank Jirka, M.D., Vice Chairman of the AMA Board of Trustees; and Bernard Harrison, AMA Group Vice President.

The sweeping drug bill before Congress signals a shift in philosophy where government takes it upon itself to protect patients from their physicians, the AMA has told the Senate Human Resources Subcommittee on Health.

The bill gives the FDA power in determining safety of a drug, such factors as abuse potential, whether the drug is being used for nonapproved uses, whether FDA believes there is a more appropriate drug or treatment, and whether the drug would have an adverse effect upon public health, the AMA witness noted.

HMOs.

The Administration's \$500 million Health Maintenance Organization (HMO) bill ran into opposition from key Senators alarmed over reports of widespread fraud and abuse.

"Wouldn't it be best to put brakes on the whole HMO program?" asked Sen. Herman Talmadge (D-Ga.), Chairman of the Senate Finance Subcommittee on Health. Sen. Sam Nunn (D-Ga.), Vice Chairman of the Senate Permanent Subcommittee on Investigations, agreed. Sen. Carl Curtis (R-Nebr.) said that if HMOs are any good, they will grow on their own without the need for any federal subsidy.

Nunn told the Finance Subcommittee that "unless remedial action is taken, the federal government, through its program of financing the development of HMOs, faces the prospect of encountering nation-wide the same kinds of scandal and abuse that have plagued the California Medicaid program." There is evidence that organized crime is moving into the HMO field, the Georgia Senator warned.

REPORTS OF OFFICERS, DELEGATES AND COMMITTEES

ANNUAL SESSION

April 30, May 1 & 3, 1978

(These reports appear as originally submitted. For the House of Delegates deliberations, possible changes, and final action, refer to the minutes which follow these reports.)

REPORT OF THE BOARD OF DIRECTORS

Charles F. Ashby, M.D., Geneva, Chairman; Robert B. Benthack, M.D., Wayne; Dwight W. Burney, Jr., M.D., Omaha; Russell L. Gorthey, M.D., Lincoln; Robert J. Morgan, M.D., Alliance.

The year 1978 demonstrates an improved financial status of the Association due primarily to the dues increase as granted by the House of Delegates. Even though we show a surplus at this time, the net amount of this figure will be determined by the financial obligations incurred during the coming year. Additionally, there will be considerations of amounts to transfer to permanent reserves. As of this report, both the Contingency and Liability funds are being utilized and a review of the continued need for these funds will be made at the end of the year.

The Board has adopted a budget of \$237,725 for this year. This budget reflects a larger increase than normal because certain administrative costs formerly charged to other funds are now absorbed in the budget.

The total fund balance on December 31, 1977, reflected a balance of \$204,006, consisting of cash, investments, plus the balance of the liability fund.

A modified format has been used for the 1978 budget. Through the division of the budget into four major categories, Internal Activity, Scientific Activity, External Activity and Medical Education, we hope to more accurately identify the specific financial needs of the

Association. One new category, New Programs, has been added to make allowance for unanticipated expense that may occur during the year.

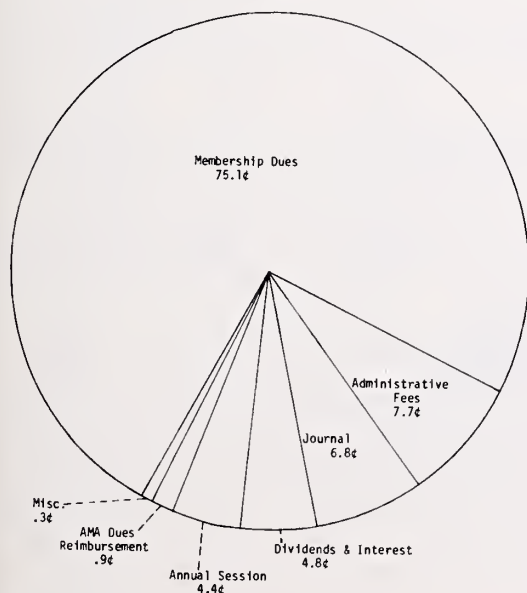
A request for an increase in printing costs of the Journal will be considered by the Board at the Annual Session. The increased cost will involve material. Our printer has been very considerate in requesting printing increases and we are most appreciative of his efforts. The Journal has reflected a modest increase in advertising income for last year. It will, however, need continued support by the Association. Various accolades have been given the Journal in recent times which we are pleased to receive. Such recognition reflects the dedication of our Editor, Doctor Frank Cole, to a quality publication.

The Board wishes to report that the Association late last year was reviewed by the Internal Revenue Service for non-profit status. We are pleased to inform you that a letter has been received from that agency giving us continuation of our 501C6 rating as a tax exempt organization.

Since the last report of the Board, a review was made of the Headquarters Office needs in terms of space. With our current lease set to expire in April, 1980, the Board felt it necessary to review those options available with regard to future space. The Headquarters Office has been used extensively by committees and related activity. Our review indicated a need for additional meeting space as well as storage and production room. Following this review, the Board directed staff to contact the building manager with regard to potential space. These discussions have resulted in an agreement that will allow the Headquarters Office to remain in the building by moving to another floor. Additional space obtained will permit a more accommodating conference and meeting area as well as expanded space for other activities of the Association. This move will assure the Association of adequate space to meet its needs both for now and in the future. The agreement calls for the Association to move about January of 1979 or sooner. While the

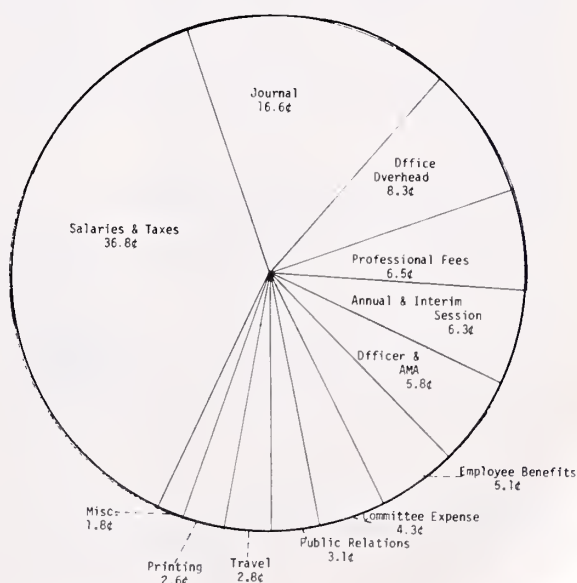
NEBRASKA MEDICAL ASSOCIATION

INCOME - 1977



NEBRASKA MEDICAL ASSOCIATION

EXPENDITURES - 1977



Headquarters Office has functioned efficiently in its present location, no additional space was available and occupancy beyond the present lease was not possible on this floor. Retention of the office in the present building will permit the Association to continue its utilization of bank, legal, and food services and reduces considerably those costs associated with moving elsewhere.

Further details on progress of the move will be made at the Fall Session.

The Board, as always, will be happy to answer any questions.

Respectfully submitted,
CHARLES F. ASHBY, M.D.
Chairman

1978 COUNTY SOCIETY MEMBERSHIP

[As of April 14, 1978]

Figures shown () indicate 1977 membership
as of December 31, 1977

County	State & AMA		No AMA		Life		Total		1978 Delinquent
Adams	27	(29)	13	(10)	9	(9)	49	(48)	2
Antelope-Pierce	9	(8)	1	(1)			10	(9)	
Boone		(2)							2
Box Butte	9	(8)			3	(3)	12	(11)	1
Buffalo	36	(34)	12	(13)	2	(2)	50	(49)	2
Butler			4	(5)			4	(5)	
Cass	3	(4)	2	(2)	2	(1)	7	(7)	
Cheyenne-Kimball-Deuel	8	(9)			1	(1)	9	(10)	
Cuming	1	(2)	4	(3)			5	(5)	
Custer	3	(3)	1	(1)	1	(1)	5	(5)	
Dawson	7	(10)	5	(1)	3	(3)	15	(14)	
Dodge	13	(16)	10	(6)	5	(5)	28	(27)	
Five County	8	(8)		(1)	1	(1)	9	(10)	1
Four County	2	(3)	2	(2)			4	(5)	1
Gage	11	(8)	7	(8)	6	(6)	24	(22)	
Hall	34	(34)	11	(17)	7	(5)	52	(56)	1
Hamilton	3	(3)	4	(4)	1	(2)	8	(9)	
Holt & Northwest	8	(10)	6	(5)			14	(15)	1
Jefferson	4	(4)	2	(2)		(1)	6	(7)	
Knox	2	(3)	2	(2)	1	(1)	5	(6)	1
Lancaster	152	(157)	55	(68)	30	(31)	237	(256)	13
Lincoln	12	(13)	23	(22)	3	(4)	38	(39)	
Madison	21	(21)	2	(4)	5	(6)	28	(31)	
Northwest	7	(12)	5	(3)	1	(1)	13	(16)	2
Omaha	416	(443)	154	(179)	56	(60)	626	(682)	59
Otoe	4	(6)	4	(5)	3	(3)	11	(14)	1
Perkins-Chase	3	(3)	2	(2)			5	(5)	
Phelps	2	(3)	4	(3)			6	(6)	
Platte-Loup Valley	11	(15)	7	(6)	1	(1)	19	(22)	1
Saline	3	(5)	1				4	(5)	
Saunders	5	(5)	1				6	(5)	
Scotts Bluff	32	(35)	20	(21)	3	(3)	55	(59)	1
Seward	7	(8)			1	(1)	8	(9)	
South Central	1	(1)	2	(3)	2	(3)	5	(7)	1
Southeast	8	(8)	6	(8)	2	(3)	16	(19)	2
Southwest	17	(15)		(1)	3	(3)	20	(19)	
Washington-Burt	8	(8)	1	(1)	4	(4)	13	(13)	
York	6	(6)	6	(5)	1	(1)	13	(12)	
TOTALS	903	(962)	379	(414)	157	(165)	1439	(1541)	92

% of Total Membership

Omaha 43.5%
Lincoln 16.5%
Out State 40.0%

1978 STUDENT AND HOUSE OFFICER MEMBERSHIPS

	U of N	Creighton	Misc.	Total
Student Members	60	32		92
House Officer Members	17	5	2	24

AGE BREAKDOWN OF NON-A.M.A. MEMBERS

Age Group	Omaha	Lincoln	Out- State	Total
Under 40	46	24	51	121
40-50	48	13	53	114
51-60	42	12	33	87
61-69	15	4	19	38
70 & Over	3	1	12	16
No Age Available		1	2	3
TOTALS	154	55	170	379

Following are the number of members upon which the number of Delegates to the A.M.A. are based:

	State & A.M.A.	State Only*	Life	Total
1975	1018	24	135	1177
1976	970	14	151	1135
1977	962	17	161	1140
1978	903	16	151	1070

*Eligible for dues exemption in A.M.A. because of age, retirement, disability, etc.

REPORT OF THE DELEGATE TO A.M.A. — 1977 CLINICAL MEETING

The most significant event to occur at the meeting will not appear in the official proceedings. It has to do with the AMA-sponsored and financed Commission on the Cost of Medical Care.

A summary of this report (15 pages) was an insert in the current issue of the AMA News. It was available on a table near the registration area but no clue as to its existence unless you happened to pick up the News and opened up its pages.

When the local press released an article on the report, the House of Delegates was alerted. All of this occurred before the House was called to order for its first session.

The California delegates submitted an emergency resolution asking that the report be made an order of business. The leadership of the AMA vigorously opposed this and the House majority sustained them.

I have attended every session of the House of Delegates except for one for about 35 years — long before I was a Delegate. I have never seen such an exhibition of the undemocratic process.

A brief summary of the Report reveals that it contained recommendations to radically restructure the practice of medicine. It advocated capitation (HMOs) practice; it advocated that medical practice be made a public utility; it recommended regionalization of special services and it recommended numerous onerous controls over medical practice which would augment those we already have as a result of Medicare-Medicaid, PSRO, Health Planning and Resource Act, and many others.

There are three AMA members of the Commission,

who were past presidents of the AMA, and yet no minority protest report was filed.

Nebraska can be proud of its record in opposing the AMA-sponsored national health insurance legislation and its consistent posture in not promulgating a PSRO in our state. Texas, South Carolina, South Dakota and Ohio have now joined our forces in opposing an AMA-sponsored national health insurance bill.

I. REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

Report E Board of Trustees: Specialty Society Representation in the House of Delegates and Other Similar Reports.

The Bylaws were amended to seat delegates from national medical specialty societies and phase out the delegates from the section councils. The specialty society must have at least 1,000 AMA members. If it has less than that and a specialty examining board, it may apply for specialty society delegate consideration. There are 37 specialty societies eligible to apply for delegate representation which have 1,000 members or more and eleven specialty societies which have an examining board but which have fewer than 1,000 members. All of these must apply to the AMA for the privilege of seating a delegate. The specialty societies will pay the expenses of the delegates. It is unknown as to how many other specialty societies meet the 1,000 member criteria. The House of Delegates will be increased from 249 to 269 and the state medical society representation will fall from 85.5% to 79.2%.

Report A of the Judicial Council: Revision of the AMA Principles of Medical Ethics.

These will be discussed at the annual session in 1978. There are serious flaws in the proposal, especially those which relate to Section 6 and to Section 10. These should be discussed at the Association meeting.

Report B. Council on Long-Range Planning: Establishment of Specialty Section Councils.

The general concept of the previous section councils is retained by the establishment of the Specialty Section Councils for the purpose of scientific, educational, and other appropriate interests concerning the specialty. The specialty societies concerned with the council will send their own representatives and pay their expenses.

Report EE Board of Trustees: AMA Presidency.

The title of the Executive Vice President was changed to Executive President of the AMA.

II. REFERENCE COMMITTEE A

Report of Council on Medical Service and Judicial Council: Confidentiality of Computerized Patient Information.

This report consisted of a set of guidelines which were adopted. It is obvious that with increasing computerization and increasing involvement of the federal government as well as the requirements of the private insurance carriers for information about patients, confidentiality will be more and more difficult to maintain.

Report JJ Board of Trustees: HEW Release of Medicare-Medicaid Reimbursement List of Physicians.

This report discussed AMA activities and policies concerning the release of this type of information by HEW. This was adopted.

Report I Council on Medical Service: Medicare Fee Profiles.

This report consisted of a discussion regarding the inequities in Medicare reimbursements to physicians with particular reference to rural-urban differences. There was no startling resolution to the problem. This was adopted.

Report F Council on Medical Service: On Certification of Need for Patients Hospitalized Under Medicare-Medicaid.

This report opposed resolution asking the AMA to notify its members that they were not legally responsible for certifying and recertifying the need for continued hospital care. Testimony indicated that the AMA should clarify the legal responsibility of doctors in this regard. No report, however, will be sent out. It was stated that a paper would be prepared for publication in the AMA News. It appeared that the AMA carefully ducked the issue.

Report D Council on Medical Service: Payment for Ambulatory Cardiac Rehabilitation.

The report was adopted and recommended that Medicare and private insurance carriers pay for cardiac rehabilitation services in physicians' offices or clinics.

Resolution 3: Abortion

This requested the AMA to advise agencies that elective abortion services rendered under Medicaid and in other third party payment programs should be recognized as compensable services. Adopted.

Resolution 51: Community Mental Health Centers.

This resolution asked the AMA to study the feasibility of examining and evaluating the effectiveness of community mental health centers and report findings to the House of Delegates. Adopted.

Report L of Council on Medical Service: PSRO and Resolution 12.

Report L summarized the current status of the PSRO program and Resolution 12 recommended opposition to use of the Medicare Provider Number for PSRO hospitals and asked for reaffirmation of Association policy preserving confidentiality of PSRO. Report L was adopted and Resolution 12 was amended to read that the AMA reaffirms its stand that PSRO-derived information shall remain confidential and not directly or indirectly identify the specific hospital, patient, or physician. This was also adopted.

Resolution 29: PSRO.

This called for a study to determine the true national cost of PSRO per claim disallowed. The resolution was amended to read that the AMA would continue to monitor and evaluate data forthcoming from studies of PSRO. (The Opel Report should be called to your attention which showed that there was no measurable difference between the cost effectiveness of a PSRO area as compared to a non-PSRO area.)

Resolution 11: Opposition to PSRO Transmittal No. 48: Level of Care

A substitute resolution was adopted which states that it should be the prerogative of PSROs to make their own determinations as to what constitutes medical necessity for continued hospitalization and that all quality assessments are inseparable and fall within the province of PSROs and other recognized forms of physician peer review organizations.

Report A Council on Medical Service: Peer Review of Non-Medicare Physicians.

This report called attention to the House that in

Illinois peer review is also conducted with regard to non-members. This was adopted and it was urged that other state medical societies follow suit.

Report A Council on Medical Service: So-pay for All Insurance Programs.

Report A recognized the importance of co-insurance for health insurance programs providing that the cost of sharing is reasonably related to the ability to pay and does not preclude access to needed care. This was adopted.

Resolution 50: Insurance Parity for Psychiatric Care.

A substitute resolution was referred to the Board of Trustees for subsequent report, recorded the AMA in support of insurance coverage which provided options for benefits that may be purchased by the subscribers and that these benefits should be clearly identified and additional cost clearly delineated.

Report UU Board of Trustees: Blue Shield/Blue Cross Resolution 64: Third-Party Carrier Discrimination Against "Non-participating" Physicians.

Report UU dealt with subject of deteriorating relationships between physicians and the Blues particularly citing new health programs, the so-called vision and hearing programs. These involved differential payments for services performed by participating and non-participating physicians. Resolution 64 was amended to read that the AMA opposed third-party differentiation between covered services by participating and non-participating physicians. Both Report UU and Resolution 64 were adopted.

Resolution 72: Utilization Review by Blue Cross/Blue Shield.

The House adopted the substitute resolution which favors the use of local physician review mechanisms in third-party utilization review activities.

Report S Council on Medical Service and Resolution 54 Both Objecting to Aetna Life and Casualty Advertising.

Report S was adopted which stressed the objection to Aetna advertising on the cost of health services.

Report K Council on Medical Service: Regarding Inappropriate Restrictions on the Use of Assistants to the Physician and Resolution 15 on the Same Subject.

Report K was amended as follows: That provisions in state legislation which prohibit the performance by allied health personnel working as assistants to and under the direction, control, and responsibility of physicians improperly restrict the ability of the physician to use effectively such personnel in patient care. Adopted.

Resolution 86: AMA Assistance on Matters Related to Health Planning.

A substitute resolution was adopted which stated that the AMA should provide assistance to constituents and component medical societies in attaining appropriate physician participation in influence on and leadership of state and local health planning efforts.

Report G Council on Medical Service: Reimbursement for Diagnostic and Therapeutic Procedures.

The report was adopted and called for third parties to seek consultation from the profession prior to reimbursement decisions.

Report B Council on Medical Service on Provision of Fee Information to Patients.

This report was adopted and recommended that physicians be urged to volunteer fee information to their patients.

Report M Council on Medical Service: Providing Copies of Patients' Hospital Bills to Physicians.

This report was filed and asked the AMA to work with the AHA to see that physicians receive copies of hospital bills of their hospital patients.

III. REFERENCE COMMITTEE B

Report L Board of Trustees: Health Professions Educational Assistance Act of 1976. PL 94-484

This report described legislation prepared by the AMA seeking amendments to this Act which require medical schools as a condition of receiving capitation funds to accept third year transfers of U.S. citizens enrolled in foreign medical schools. Adopted.

Report N Board of Trustees: California Radiation Law

This called for development of model state legislation similar to the present concept regarding radiologic technologists in the current California Radiation Law. Adopted.

Report R Board of Trustees: Fiscal Notes as Part of Federal and State Health Programs.

The report described the draft federal legislation requiring preparation and publication of economic impact analyses for all federal regulations promulgated, and a model state bill which would require proposed state legislation to have fiscal notes on all bills. Adopted.

Report Y Board of Trustees: Nuclear Regulatory Commission.

This recognized the adequacy of present regulation of medical use of nuclear materials. Adopted.

Report GG Board of Trustees: Support of HR 5150.

This requests AMA to support legislation providing payments for medical services and treatment of injuries arising from the bombing of Hiroshima and Nagasaki in Japan. The Council on Legislation is reviewing this and will report at the next meeting.

Report N Council on Medical Service: Opposition to Direct Medicare Payments for Physician Extenders.

Report N reaffirmed AMA policy in opposition permitting payment to physician extender. Adopted.

Resolution 38: Extension of Certificate of Need to Physicians' Offices.

A substitute resolution was prepared which stated that the AMA would join a state medical society if that society commenced an appropriate legal action challenging a state certificate of need law that included physicians' offices. Adopted.

Report U Board of Trustees: Certificate of Need for Federal Hospitals and HMOs. Resolution 56.

Report U stated that Council on Legislation prepared a draft bill which would subject federal health facilities and HMOs to the same health planning regulatory mechanisms as non-federal hospitals.

Resolution 56 requested development of legislation to place VA hospitals under the same health planning, utilization review, PSRO and other federal requirements imposed upon private hospitals. A substitute resolution was adopted which asked the AMA to introduce legislation which would place all governmental institutions, whether they be federal, state, county or municipal, under the same health planning, PSRO and other federally mandated health care requirements. Adopted.

Resolution 57: Opposition to National Guidelines for Health Planning.

An amended resolution was adopted which opposed

the content of guidelines published in the "Federal Register" on September 23, 1977, and that the AMA embark on a study to verify the drastic effect on hospital and medical services which could result from these guidelines. In addition, the AMA and its constituent associations were asked to widely publicize the deleterious effects that these ill-conceived regulations would have. The AMA supports the principle that the local and regional health systems agencies with their indigenous problems establish their own criteria for medical facilities. This was adopted.

Report K Board of Trustees, and Report Q Council on Medical Service: Supporting the AMA Comprehensive Health Insurance.

In addition there were nine resolutions most of which opposed the AMA insurance program. The House adopted Report K of the Board of Trustees and Report Q of the Council on Medical Service reaffirming its support of AMA-sponsored national comprehensive health insurance legislation.

IV. REFERENCE COMMITTEE C

Report I Council on Medical Education: Medical School Accreditation.

This called for the Council on Medical Education to have the authority to approve the policies of the liaison Committee on Medical Education. This was adopted.

Resolution 21 and Resolution 47: Student Awareness of the Cost of Health Care.

A substitute resolution was adopted which calls for AMA to encourage medical schools to augment their education programs in order to make medical students, house staff, and faculty more aware of the cost of health and medical care. It also asked representatives on the Liaison Committee on Graduate Medical Education and the Liaison Committee on Continuing Medical Education to encourage programs of graduate and continuing medical education to increase their awareness of the understanding of physicians' cost of health and medical care.

Resolution 67 and Resolution 78: Nutrition Courses in Medicine.

A substitute resolution was adopted which recommends teaching of adequate nutrition courses at elementary and high schools as well as medical schools.

Resolution 80: Minority Underrepresentation in Medicine.

A substitute resolution asking the AMA to investigate ways to meet the goals of minority medical students and report back to the House of Delegates at the 1978 interim session.

Resolution 82: Deferment of State Guaranteed Loans During Graduate Residency Training.

The House adopted a substitute resolution which asks the AMA to survey state and medical societies regarding their policies for repayment of loans to medical students. Findings will be reported at the 1978 annual convention.

Report J Council on Medical Education: Data on Primary Care Residents Entering Primary Care Practice.

Report J was a preliminary report from the results of a questionnaire sent to program directors in 1,200 hospitals. Part of the report was amended to call on the Council on Medical Education to continue to monitor and refine the study regarding the number of physicians entering and completing such residencies. This was adopted.

Report K Council on Medical Education: Postgraduate Year One Training.

The report evaluated opportunities for training in the first graduate year in the broad field of medicine. The Council is undertaking a study to assure the availability of adequate breadth of clinical experience for physicians about to enter more limited specialties. This was adopted.

Report L Council on Medical Education, Report M, and Report N, and Report O. Essentials of Approved Residencies in Family Practice, Ophthalmology, Therapeutic Radiology, and Pediatrics. Adopted.

Report E Council on Medical Education: Fallacy of Physician Recertification.

Report E outlined existing policy on recertification of physicians reiterating the need for continuing scrutiny of methods of assessing competition. An Ad Hoc Committee of the Council was to be formed to study the matter intensively, the purpose of which is to guide the profession in establishing the best method to document the continuing competence of the practicing physicians.

Report I Board of Trustees: Committee for Foreign Medical Graduate Affairs.

This described the formation of an Ad Hoc Committee on Foreign Medical Graduates. Adopted.

Report G Council on Medical Education: Foreign Medical Graduates.

This describes the efforts by the Council in monitoring laws regarding foreign medical graduates and the so-called "Fifth Pathway" by which a student in or graduate of a foreign medical school could qualify for admission to an accredited graduate program in the United States. This was adopted.

Resolution 79: Medical Care and Education in the Armed Forces.

An amended resolution asked the AMA to confer with Congressional Armed Services Committees, etc. in an effort to identify causation and seek solutions to the problems of medical care and education. This was adopted.

V. REFERENCE COMMITTEE D

Report H Board of Trustees: Primary Responsibility for Hospitalized Patients.

This is a policy statement on the primary responsibility for hospitalized patients. This is too lengthy to be abstracted but should be made available to hospital boards of trustees and to hospital medical staffs.

Report RR Board of Trustees: Hospital Privileges for Podiatrists.

The report recommends that medical staffs be advised to evaluate the credentials of each podiatrist who applies, make recommendations on granting practice privileges with accordance with the individual's training, experience, and demonstrated competence and judgement. Adopted.

Report TT Board of Trustees: Voluntary Cost Containment.

This was a proposed plan to achieve cost containment on a voluntary basis. Adopted.

Report H Council on Medical Service: Guidelines for Physicians Attending Patients in Long-term Care Facilities.

The report was amended about half of these. These are too extensive to be abstracted but the final form which will appear in the proceedings of the House in June

should be made available for physicians who are involved in patient care and long care facilities. Adopted.

Report O of Council on Medical Service: Patient Level of Care Determination.

Report O pertains to amendments to federal and state regulations for Medicare and Medicaid which would allow short-term care hospitals to reclassify a patient's status to that of skilled nursing care if requested by the physician. The report was amended to read that it be the prerogative of PSROs or other existing utilization committees to make their own determination as to what constitutes medical necessity for continuing hospitalization. Where PSRO review is not in effect these be made by existing utilization committees. It asks the AMA to go through appropriate channels to urge federal officials to rescind or reconsider any regulations or guidelines which would restrict this federal prerogative. Adopted.

Resolution 36: Medical Staff Selection of Representatives on Hospital Boards of Trustees.

A substitute resolution was adopted that the Joint Commission be urged to incorporate in their standards that physicians, where not legally prohibited, who are members of the medical staff shall be eligible for and full membership on hospital governing boards. The medical staff should have the right of representation at all meetings of the governing body and medical staff members should be elected by the medical staff. It was further urged that this be communicated to state medical societies. Adopted.

Resolution 46: The Professional Ethics and the Legality of Certain Special Arrangements for Teaching of Housestaffs.

A substitute resolution was adopted which opposed mandatory delegation for the diagnosis and treatment of private patients primarily to the housestaff physicians in the teaching hospital. It also reaffirmed an AMA position that one physician should be responsible for the overall care of the patient in the hospital. Adopted.

Resolution 49: Liability of the Hospital Medical Staff Physician for Obligatory Services Rendered as the Agent of a Hospital Corporation.

This resolution requested the AMA to seek immediate modification to hospital accreditation standards that unnecessarily expose medical staff physicians to personal medical liability in performing services as an agent of the hospital. Adopted.

Resolution 61: Elimination of the 60-day Recertification Visit to Nursing Homes Under Title XIX Medicaid Regulations.

This asks the AMA to request the Department of HEW to revise its regulation by elimination of 60-day recertification requirement and in its place use medical necessity as the basis for the physician to see the nursing home patient. This was not adopted.

VI. REFERENCE COMMITTEE E

Report B of Council on Scientific Affairs: Patient Instructional Leaflets.

The report opposes mandatory patient package inserts for all drugs and recommends careful evaluation of the impact of patient instructional leaflets on the quality of medical care. Adopted.

Report C of Council on Scientific Affairs: Statement on the Use of Amphetamines in Obesity.

This report informs the House of Delegates that the

Food and Drug Administration is proposing to delete the indication in the physician package insert that amphetamines may be used in the short term treatment for obesity. The report recommended opposition on the grounds that this is an unwarranted intrusion by a regulatory agency into the practice of medicine. Adopted.

Report D of Council on Scientific Affairs: Health Aspects of Marihuana Use.

The report outlines the adverse consequences of marihuana and recommends discouragement of its use, concentrated research to determine consequences of long term use and reduction in the severity of penalties governing possession and for personal use. It points out that the sale and possession of marihuana are criminal offenses under federal law and that the sale is a crime under all state laws and possession is a crime under most. It points out that there is a trend towards modification of marihuana possession laws to reduce severity of penalties. Penalties in the form of fines should be adopted to possession of small amounts and criminal sanctions imposed for trafficking. Adopted.

Resolutions 13, 23, 34, and 45: Statutory Recognition of Death.

A substitute resolution was adopted which stated that AMA reaffirm the established policy that death shall be determined by the clinical judgment of the physician using the necessary available and currently accepted criteria. "Permanent and irreversible cessation of the brain constitutes one of the various criterias which can be used in the medical diagnosis of death." It also emphasized that provision should be included to assure the physician's right to exercise his medical judgment in diagnosing death. Adopted.

Resolution 83: Promotion of Exercise.

An amended resolution was adopted which states that the AMA continue to support the promotion of exercise and encourages physicians to prescribe exercise for their patients. It asked the Board of Trustees to consider the feasibility of developing a public and professional education program emphasizing the advantages of regular exercise.

Report A of Council on Scientific Affairs: Statement on Parent and Newborn Interaction.

This report includes emphasis on the importance of parent and newborn interaction and asks that medical staffs of hospitals be encouraged to review hospital policies and practices. It further asks that the medical staffs develop and formulate guidelines relating to all aspects of professional support for the birth and nurturing processes. Adopted.

Report D of Board of Trustees: International Cooperation and Standards in Experimentation and Approval for Use of Drugs.

This was in response to Resolution 76 at the annual 1977 session. This was forwarded to the FDA for discussion with the Commissioner in an effort to begin implementation of procedures to require the FDA to accept foreign data on clinical investigation of new drugs. Adopted.

Report E of Council on Scientific Affairs: Airbags, Seatbelts, and Prevention of Vehicle-Related Injuries.

This report reviews the available studies in the effectiveness of devices to prevent vehicle-related injuries. It calls on medicine to assume a leadership role in preventing injuries by supporting the development of effective passive crash protection systems and their

mandatory installation at the earliest time when effectiveness is proven. Adopted.

Report W of Board of Trustees: Reliability of Laboratory Procedures.

This report stated that the Council on Scientific Affairs has assembled a group of consultants to study the data relating to laboratory procedures and to respond to the allegations of laboratory error in the HEW "Forward Plan for Health, Fiscal Years, 1978-1982." (This HEW report referred to laboratory errors based on studies made as much as 30 years ago.) The Report W of the Board of Trustees was filed.

VII. REFERENCE COMMITTEE F

Report V of Board of Trustees: Criteria for Billing for AMA Membership.

This report recommended the adoption of nine criteria regarding billing for AMA membership and alleged that there would be a better arrangement between AMA and the county or state society billing for AMA. This remains to be proven. The report was adopted and referred to the Board of Trustees.

Report BB of Board of Trustees: Ad Hoc Committee on Services to Young Physicians.

This outlines the recommendations of the Ad Hoc Committee related to the promotion of current AMA services to its members. A full report on services to young physicians will be sent to all state medical societies. Adopted.

Report LL of Board of Trustees: Reduced Dues for Members in Their First Year of Practice. Resolutions 18, 19, and 77 regarding Dues and Membership Solicitation.

Report LL was adopted which described a study in progress to determine the financial and membership impact of a reduced schedule for dues for new members. It will be reported to the 1978 Annual Meeting.

Report QQ of Board of Trustees: Survey Research Findings and Selected Programs. Resolutions 73 and 75 on Public Relations.

Report QQ described progress in implementation of programs proposed in the previous Report FF, A-77. It covers the expanded Speakers Bureau, direct interviews with selected physicians, a corporate advertising program, and a long-term consumer attitude survey. Report QQ was adopted.

Report SS of Board of Trustees: Legal Counsel Advice Prior to Reference Committee Hearings. Resolution 28, Legal Counsel Advice.

The Report SS describes procedures which are now currently being used to assure that the legal aspects and ramification of resolutions and reports received appropriate attention. Resolution 28 asks that the Board of Trustees establish a mechanism whereby the House would have available, prior to Reference Committee hearings, appropriate legal services concerning resolutions. Report SS was referred to the Trustees and Resolution 28 adopted.

Address of the President: Aggressive Moderation.

President John H. Budd, in his address to the House, stressed moderation and unity within the profession. He emphasized that medicine's record of service to the health of the nation often goes unrecognized while the issues are debated by society at large. The address was filed and was well received.

VIII. REFERENCE COMMITTEE G

Report A of Board of Trustees: Use of Consent Calendar.

Report A discusses the problems surrounding the use of a consent calendar. This has to do with a mechanism as to disposition of a resolution before a reference committee which received no discussion. Should it be dropped from consideration? The Report noted that the consent calendar format is being used on an experimental basis by one of the reference committees at this session. Report A was adopted.

Report G of Board of Trustees: Impaired Physicians.

This report informed the House about future plans concerning the problems of impaired physicians including resident physicians. Report was filed.

Report MM of Board of Trustees: Women Physicians and the AMA. Resolution 5, Women Physicians.

A substitute resolution for Number 5 asks the AMA to undertake a study to determine the number of women physicians who hold elective or appointive office positions in the AMA and its component societies. It asks the AMA to analyze this data and develop plans of action to increase participation of women physicians. This was adopted.

Resolution: Proficiency in Advanced Cardiac Life Support.

Substitute Resolution 44 recommends that all licensed physicians remain proficient in basic cardiopulmonary resuscitation and also in advanced cardiac life support commensurate with their responsibilities in critical care areas. Adopted.

IX. REFERENCE COMMITTEE H

Report J of Board of Trustees: Health Care Quackery. Resolutions 24, 25, and 26, all referring to quackery.

Report J outlines historical roles of AMA in combating quackery and the current Association activities in this area. (It should be pointed out that this is an area, particularly since chiropractors have been permitted to receive payment for services, fraught with potential lawsuits.) Report of Trustees filed and Resolutions not adopted.

Resolution 41: Council Representation on Reference Committees.

This recommended that no delegate, who is also a member of an AMA council, should serve on a reference committee. Many members of the House of Delegates have been convinced for years that this is a conflict of interest. The Resolution was not adopted.

Resolution 68: The Role of Reference Committee in the AMA House of Delegates.

Substitute resolution emphasized that the AMA should at all times seek to reflect the considered opinion of the Association's physician members and that members of the Reference Committee should make informed decisions on the basis of testimony heard in open hearings and on the basis of background information supplied by resource personnel. It emphasized that the recommendations developed by the Reference Committee are the responsibility of the members of the Reference Committee. Adopted.

Resolution 70: Safeguarding Human Rights.

This called on the AMA to dedicate itself to preservation of human rights and the American political system. Substitute resolution calling for the AMA to affirm its dedication to our constitutional form of government was adopted.

X. MISCELLANEOUS

Awards:

Luis Martin Perez, M.D., of Sanford, Florida, received the 1977 Dr. Benjamin Rush Bicentennial Award. William P. Longmire, Jr., M.D., of Los Angeles, will receive the Distinguished Service Award at the 1978 Annual Convention.

Memorial Resolution:

One Memorial Resolution was of special importance to Nebraskans. This referred to the death of Kenneth C. Sawyer, M.D., of Denver, Colorado. He was a close friend of many of us for many years.

Respectfully submitted,
JOHN R. SCHENKEN, M.D.
Delegate to the AMA

REPORT OF DELEGATE TO AMA — SPECIAL REGIONAL MEETING, DALLAS, TEXAS

A special regional meeting was held on March 23, 1978, in Dallas, Texas which was one of five or six such regional meetings being tried on a first time basis which provided an opportunity for Delegates, Alternate Delegates, and Medical Association Officers to participate in a forum with AMA Trustees and Officers.

The following subjects were discussed:

1. CAP vs Voluntary Cost Containment
2. JCAH — a new image?
3. Report of AMA's National Commission on the Cost of Medical Care
4. Important Health Legislation
 - a. Cost Containment
 - b. Amendments to 93-641
 - c. Approval of New Drugs
 - d. Clinical Laboratory
5. AMA Membership
6. AMA Advertising Campaign
7. AMA House of Delegates

Discussion of the AMA's bill on NHI (HR 1818 and S 218) was avoided and no comments on PSRO were received. This format seemed to provide an opportunity for state representatives to ask searching questions in an open forum and get straight answers to some of the questions troubling them. Your Delegate believes that these regional meetings provide an opportunity to impact on the AMA leadership which has been lacking in the past.

Respectfully submitted,
C. J. CORNELIUS, JR., M.D.
Delegate to the AMA

REPORT OF THE NEBRASKA MEDICAL FOUNDATION, INC.

The annual report of the Foundation does not change dramatically from year to year. As in the past, this report will reflect our continued growth.

Student loan applications continue to be received, reviewed and with few exceptions are approved and granted. The usual time frame for consideration of a loan application from time of receipt to approval may be as brief as two days. We continue to see the program as a supplement to Federal loan programs which can provide loans to medical students at a lesser interest rate. One limitation of those programs has been their inconsistency, and amount available to student applicants. I am pleased to report the Foundation continues to have adequate funding to guarantee

loans. This is due to the faithful and continuous support received from the membership and to the on-going efforts of the Auxiliary. We are most appreciative of the Auxiliary's efforts and the important contribution they make to the success of the loan program.

Loans granted since May, 1977 (30), \$53,400. Contributions since May, 1977, from all sources, \$4,462. Total loans since 1964, 1,158, and total amount loaned since 1964, \$1,301,330.

You will recall that in my report of 1977, it was announced the Foundation would begin a scholarship program as part of an expanded activity. Funds for this scholarship were derived from research funds which have been accumulated by the Foundation through gifts from medicine and from the public. At the 1977 Annual Session, two students, one from Creighton University School of Medicine and the other the University of Nebraska College of Medicine, were presented with one-half of their scholarship (\$500). These students will receive the remaining half after they complete their research project and submit a report to the Foundation which will be due prior to this Annual Session. The Foundation is optimistic about the scholarship endeavor and is vitally interested in seeing it increase both in the amount and numbers available to medical students. To this end, I make a strong plea to both Association members and our Auxiliary to make contributions to our scholarship program so that it may grow to be as successful as the loan program. We clearly do not mean this to replace our very valuable loan program, but rather consider it an adjunct and extension of our activity. I am sure with your support we will not only successfully continue our loan program but also develop a very worthwhile and effective scholarship activity. This in my opinion demonstrates our dedication to the cause of student education in medicine.

Respectfully submitted,
LOUIS J. GOGELA, M.D.
President

REPORT OF THE UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE

Mr. Speaker, members of the House of Delegates, distinguished guests.

I find it a real pleasure to be able to personally present this report to the House of Delegates. I regret that I was unable to attend your meeting last fall because of a prior commitment. Actually, the timing probably is more favorable since I can speak to you today with almost a year of experience as Chancellor of the Medical Center.

I would like to share with you some impressions of the Medical Center I have formed during the past ten months and would also like to outline areas where progress has been made and areas where problems have not yet been solved.

One of the first issues brought to my attention in Nebraska was that of rural health and the role the Medical Center should play in the solution of statewide problems of this type. Last summer I appointed a task force to explore this issue. The task force was chaired by Dr. Paul Young, Chairman of our Department of Family Practice. It has submitted a preliminary report which contains a number of observations and recommendations. Our Rural Health Task Force was composed primarily of full-time faculty and staff but did include Dr. Tollefson from your Rural Health Committee as well as Dr. Leo Lucas, the Dean of the

University's Cooperative Extension Service in Lincoln. It maintained a close liaison with the Governor's Commission on Rural Health and continues to do so. We are already making some progress in implementing the Task Force's recommendations.

The Task Force noted that we have received relatively few applications to medical school from students in rural areas. In fact, in the past year, 55 counties in Nebraska produced a total of only 22 applicants to the College of Medicine. All of these counties were rural counties. In an effort to interest more rural students in health careers, a group of Medical Center students have organized a program aimed at High School students in smaller Nebraska communities. On their own initiative, the students prepared a slide-sound presentation and are visiting communities in the state to meet with high school students, high school counselors, health professionals, and other community leaders. The program describes career in health and is being taken by the student teams to several rural communities this month.

As another element of its program in rural health, the College of Medicine has increased the duration of its rural health preceptorships for medical students from four weeks to eight weeks. I believe it is valuable for medical students to learn about good medicine as it is practiced in a rural area at an early and formative stage of their careers.

One recommendation of both the Governor's Commission and our Task Force was the establishment of a student loan forgiveness program. As you may know, Senator Richard Maresh introduced a bill in the legislature to begin such a program. This bill, LB 884, was passed, signed by the Governor, and goes into effect next year. For each year of practice in a shortage area of the state one year's loan incurred during medical school will be forgiven. I believe this program has a good chance of success. Certainly, our students have expressed great interest in it.

The Medical Center has also received a grant from the W. K. Kellogg Foundation to study and perhaps implement a statewide residency program in primary care specialties in cooperation with Creighton and the Lincoln Medical Education Foundation. This grant also will finance a study of the feasibility of establishing a Family Practice residency in the Grand Island-Kearney-Hastings area, a program which has been urged by members of the legislature and others.

In cooperation with the University's Cooperative Extension Service, the Medical Center has written a grant proposal proposing a health education program for the public in six rural areas of Nebraska. Should this proposal be funded, we believe it will enable rural residents to more effectively use the health care resources available to them.

Before leaving the subject of rural health I would like to reemphasize something we have stressed before. While the Medical Center is fully committed to doing its part to find solutions to the rural health problem, it cannot solve this problem alone. Any final "solution," and I hesitate to use the term solution because the problem is a complex one and will in fact need "many solutions," will require the help of state government, your help, and the help of rural residents themselves.

Turning to another area, last fall we organized a Task Force on Research at the Medical Center. This task force just recently made its report to me. Since the report has not been circulated to all members of our faculty as yet, the only comment I can make at this

time is that the task force concluded we are doing considerably less research at the University of Nebraska Medical Center than is being done by comparable medical centers around the country. We do need to improve our track record in this important area of endeavor, the task force has made a number of specific recommendations, and we will be implementing these recommendations during the next year.

As you know, considerable effort on the part of many individuals was spent during the first half of the 1977-78 academic year to develop a new plan to handle professional fee income generated by clinical faculty in the College of Medicine. A plan was developed and was approved both by a large majority vote of the clinical faculty and by the Board of Regents.

The new professional fee plan, which goes into effect in July of this year, provides what I consider to be adequate reporting and control mechanisms while at the same time retaining the incentive principle. As an aside, I would congratulate both the faculty of the College of Medicine and the Regents for the considerable restraint they have exercised in dealing with what is always a controversial matter in a medical school.

I would also like to comment briefly on the Medical Center's budget for the coming year. It is lean and it is tight for both the Medical Center and the entire University. There is no money for new programs, no money for improvement in existing programs, and essentially no new money to enable the Medical Center to cope with inflation in the costs of goods and services.

The University's emphasis this year was on the improvement of faculty salaries, but to reach the 8% increases directed by the Regents the University will have to use up to \$2 million in cash funds which are available on a one-time basis only. Needless to say, we anticipate a cautious year ahead.

Finally I would like to report on the progress which is being made in the search for a new dean of the College of Medicine. As you know, Dean Perry Rigby announced his resignation in February. A search committee was appointed immediately and is now hard at work. In addition to representatives from the full-time faculty, the search committee membership includes Dr. Tollefson, Dr. Charles McLaughlin, and Dr. Gerald Schenken from our part-time and volunteer faculties.

In conclusion I would like to pledge that I will do everything possible to maintain a close working relationship between the Medical Center and organized medicine. In past positions both in Michigan and in Arizona I have always tried to do this because I believe that a relationship of this type is of vital importance to any academic medical center. I believe that by working together we can achieve a great deal in improving health care in Nebraska and I welcome this opportunity to become better acquainted with each of you.

Thank you for inviting me to your meeting.

Respectfully submitted,
NEAL A. VANSELOW, M.D.
Chancellor

REPORT OF THE CREIGHTON UNIVERSITY SCHOOL OF MEDICINE

As I prepare this report for you this spring, Creighton University is already one quarter of the way through its centennial anniversary of its founding.

Observance of this historic and sobering anniversary has dominated the extraordinary academic and non-academic activities of the entire university this spring. Scores of lectures, seminars, testimonials, and awards have been planned to remind the university family and the community of this century-long presence of Creighton in Omaha and the mutual benefits that have resulted from this enduring presence. The School of Medicine has joined in this celebration through special programs and programs of continuing medical education, and invites all members of the Nebraska Medical Association to join us during the year in this observance.

Just as the first quarter of 1978 for the university has been dominated by the celebration of its centennial, so has the first quarter of 1978 for the medical school been dominated by the long awaited relocation of Saint Joseph Hospital on the university campus. The move from old quarters to new quarters was accomplished during the week-end before Christmas, 1977. This massive undertaking was accomplished with remarkable smoothness and only minimal disruption of patient-care responsibilities of the hospital and medical faculty. In fact, four months after the move, as is often true with humans who suffer pain, it is difficult to even remember the discomforts that occurred. The relative ease with which this transition took place is largely to the credit of the outstanding planning that took place by the hospital staff and the substantial assistance offered by other agencies in the community including the University of Nebraska Medical Center.

The relocation of the hospital to the university campus has established a physical presence for the hospital as a part of the university academic life and has resulted in an increased awareness by the entire university of the hospital and the role it plays in supporting the academic programs of the university in the health professions. Its presence is a constant reminder to faculty, administrators, and staff alike of the interdependence of the two institutions. The sharing of resources and services made possible by the move and by the presence of the other partner in the enterprise — The Boys Town Institute for Communications Disorders in Children — have made it necessary to develop new mechanisms for management interaction to facilitate decision making in a variety of areas impacting three distinct corporate entities. I am extremely pleased to report that these mechanisms are functioning very well — if still imperfectly — and more of us are learning more and more about the meaning of mutual dependence.

Physical changes have also been accompanied by some program changes. The university and the hospital have jointly initiated new programs in oncology under the direction of Doctor James Mailliard and soon will initiate a new program in ophthalmology under the direction of Doctor Ira Priluck. Doctor Michael Sketch has succeeded Doctor Vincent Runco as Director of Cardiology. We anticipate being able to make significant announcements in the near future concerning program leadership in pathology, and obstetrics and gynecology.

Next month, 111 new physicians will be graduated with the degree, Doctor of Medicine and will enter the next stage of their preparation for assumption of patient care responsibilities in our health care system. Of the 94 of these new graduates participating in the National Intern and Resident Matching Program, 27 will remain in Nebraska for their post-graduate training. In all, 32 of these graduates will undergo

training in the contiguous states of Nebraska, Iowa and Kansas. Students not participating in the NIRMP generally are those with a military obligation following graduation and will assume additional training assignments at the discretion of their branch of service.

During my reports to at least the last two meetings of the House of Delegates, I have alerted this group as to the nation-wide decline in the number of applicants to medical schools. This decline is now in its fourth consecutive year and is a matter of increasing concern to medical educators, particularly those of us in private medical education. While the number of applicants is still sufficient to assure an entering class of high quality, a 20% decline in the last four years suggests that either the attractiveness of the medical profession is diminishing or the cost of medical education is imposing an unacceptable strain on many young men and women. We continue to maintain surveillance of our contract program with the State of Wyoming and are increasingly convinced the program fulfills needs that exist at Creighton as well as within Wyoming. In addition, we are actively exploring a potentially historic step involving a long-term contractual relationship with an educational foundation in Japan.

In recent years I have also from time to time made reference to national health manpower legislation. I am sure most of you are aware by this time that the more onerous provisions of the existing Health Manpower Act pertaining to acceptance of U.S. students studying medicine abroad have been repealed. This welcome relief from an obligation that would have severely strained our educational resources was recently followed with a waiver of a mandatory enrollment increase associated with construction programs. Thus, it appears that for the foreseeable future and at least until the next accreditation survey by the Liaison Committee on Medical Education our entering class size has "peaked" at the present level of 110 students.

Having just made reference to our next reaccreditation survey by the Liaison Committee on Medical Education, it now appears that such a survey will be conducted during the 1979-80 academic year, and we are quite confident that we can continue the unqualified accreditation under which we currently operate.

Finally, while it is probably somewhat inconsistent with the general purpose of this reporting session, I would like to publicly acknowledge for this group the recent passing of the foundress of Creighton University, Mrs. Mabel L. Criss. Not only Creighton University and our School of Medicine, but higher education in general in Omaha and Nebraska have benefited greatly from the philanthropy of this most generous woman. It is a debt that I wish to acknowledge and to share.

Respectfully submitted,
JOSEPH M. HOLTHAUS, M.D.
Dean

REPORT OF THE UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE

As of July 1, 1978, I am resigning as Dean of the College of Medicine. After serving in this capacity for four years, I look forward to returning to academic pursuits within this college. I will be working in the Hematology Division and in the Department of Internal Medicine, caring for patients, teaching students and residents, and resuming my research efforts.

I am proud of the record and accomplishments of the College of Medicine during my tenure and am very grateful to the many people who worked and assisted in supporting and improving this college. Special appreciation must go to the Dean's Staff, Assistant and Associate Deans, and all of the faculty, students, and alumni who have shown sincere interest in our multi-faceted approach to excellence in medical education, patient care and research. These individuals have demonstrated their interest by hard work and unselfish cooperation while working toward common goals.

Progress in the College of Medicine in recent years has come in a variety of forms. At present the College has the largest number of students, faculty and educational programs in its history. Quality has more than kept pace with increases in size, as the curriculum has undergone steady evaluation and revision to ensure excellence and to keep abreast of changing demands on medicine. A new revised four-year curriculum will be available to students who enter in July of 1978. Through improved educational programs and expanded enrollments, the College continues to provide physicians of competence and dedication to meet the health care needs of the state.

Research in basic and clinical medical science is also progressing. In order to foster such development, additional funds will be needed in the future for research space and other research facilities.

Improving patient care and greatly increasing patient census are representative of progress in University Hospital. The University Clinic Building (formerly called the Ambulatorium) was dedicated in October of 1977. Construction on the 103,000 square foot building was started in November of 1975, and the clinic is now open to provide services for an expected 80,000 outpatients a year. This structure will allow for emphasis on ambulatory care in the education of medical students and will provide an excellent setting for improved postgraduate medical education.

A major problem which the College of Medicine faces at present is the stability and adequacy of future funding. In June of 1977, this College experienced a budget reduction of \$1,300,000, due to loss of federal and other funds. Approximately one-half of this loss was absorbed by the Dean's Office through retrenchment in such areas as new faculty, staff salaries, equipment purchases, remodeling and program development. Other reductions were achieved across all departments of the College through release of staff (both faculty and non-faculty), decreased operating budgets and reduction of funds normally used for program development. Concerted effort has been made to replace lost funds.

It is expected that the College will continue to grapple with problems of resources and budget in the foreseeable future. Continued support is necessary from all concerned if the College is to maintain the level of progress it has achieved to this date. Commitment to a well-organized, high-quality program of health education, service and research are essential to provide opportunities for and address the needs of the citizens of the State of Nebraska. I urge your continued support for the new Dean upon his or her appointment. I would again thank you for your support throughout my administration.

Respectfully submitted,
PERRY G. RIGBY, M.D.
Dean

REPORT OF THE STATE HEALTH DEPARTMENT

The opportunity to make this report is greatly appreciated. There are several program elements and some public health trends that seem timely.

Many of you may know that Dr. Kenneth Kimball from Kearney has taken over medical direction of our Emergency Medical Services Program. Over the past five months, he has very energetically strengthened the professional aspects of the program and greatly advanced the systematic approach to all facets of EMS in Nebraska.

The Department has launched a major diabetes project to put together all methods that have proven effective to physicians and their patients with diabetes. Dr. Robert Recker is chairman of a very active advisory committee that includes five other physicians. We are optimistic that this combined, broad-based approach will prove helpful to all who deal with this frequently encountered chronic disease.

You and your colleagues have continued to do a superb job in immunizing school age children. Nebraska rates very well in achieving protection of this group. Our immunization efforts this year are focused on bringing the immunization status of pre-schoolers up to a uniformly effective level.

Again last year Nebraska led the nation with the lowest tuberculosis rate among the states and territories.

Finally, let me bring to your attention the significant drop in deaths by Nebraskans from cardiovascular causes over the past two years. Your effective treatment of hypertension and obesity and counselling on living patterns such as avoidance of smoking and the promotion of sound dietary and exercise regimens are truly having an impact.

Respectfully submitted,
HENRY D. SMITH, M.D.
Director

REPORT OF THE HEALTH PLANNING COMMITTEE

C. J. Cornelius, Jr., M.D., Sidney, Chairman; Roger W. Dilley, M.D., Fremont; Robert J. Fitzgibbons, M.D., Omaha; S. I. Fuenning, M.D., Lincoln; F. H. Hathaway, M.D., Lincoln; James E. Ramsay, M.D., Atkinson; Stanley M. Truhlsen, M.D., Omaha.

The Health Planning Committee has been deluged by volumes of material since the last meeting of the House of Delegates. This deluge has been Federally inspired for the most part relating to activities delineated by PL 93-641, The Health Planning and Resources Development Act of 1974. This is the year that the Health Systems Agencies are required to develop and publish their first Health Systems Plans (HSP-5 year plans) and their first Annual Implementation Plans (AIP-first year action plans). The Stage Agency, SHPDA (State Health Planning & Development Agency), a division of the Health Department in Nebraska, is required to integrate these documents and come up with a State Health Plan. All of these plans require review by the Systems Planning Committee (of which your Committee Chairman is also Chairman) of the SHCC (Statewide Health Coordinating Council — appointed by the Governor and in turn accepted or rejected on review by the entire SHCC before being sent on through the

Federal Review cycle to the Region VII office and then to the Washington Office of HEW. If this process sounds somewhat confusing, it's because it is. Enough about the organizational structure. There is considerably more to it including 1,122 review and CON (Certificate of Need) preparations, etc.

On September 23, 1977, HEW issued the first set of guidelines for HSA's and SHPDA's to use in developing their plans. These so-called guidelines read like standards promulgated from "on High" rather than goals developed at the grass roots level as PL 93-641 purportedly intended. There were "11" guidelines and with the exception of #XI, which was a restatement of the End Stage Renal Disease Program which is already in place, all created problems for the delivery of medical care in Nebraska. Your committee enlisted the input from the various specialties involved and received excellent information from all physicians invited to comment. The committee then developed a response to these guidelines which was submitted to the Department of HEW and copies were sent to the members of our Congressional delegation. The response to these guidelines was vehement if not downright antagonistic the country over, particularly in the rural areas. Significant revisions were made in these guidelines as a result of the multitude of comments received by HEW. However, the most significant result of this upheaval is that Congress recognized that it was necessary for it to reaffirm the legislative intent for grass roots development of health plans and to exercise ongoing surveillance over further rules and regulations developed in the implementation of PL 93-641. The 1978 amendments to 93-641 indicate that Congress has finally recognized the difference between direct and indirect providers of medical care and includes one which requires that 50% of the providers on HSA boards be direct providers.

At the present time, members of the Health Planning Committee are reviewing the HSP's and AIP's and comments regarding same are being compiled. Comments from several members of the Association outside the committee with special interest in these plans have also been solicited, and comments from any member of the Association will be welcomed by the committee. Please mail your comments to the Health Planning Committee in care of the NMA Headquarters Office in Lincoln.

The Health Planning Committee in conjunction with the Health Education Committee recently responded to the "health education proposals" from the HSP's at the request of the SHPDA division of the State Health Department.

There are a number of controversial proposals included in the HSP's and AIP's which merit ongoing study by all members of the NMA. The final form of the CON (Certificate of Need) bill, if approved by the Nebraska Unicameral, will have far reaching implications for all members of the Association. Your Committee intends to continue to monitor the development of these health plans and will alert the membership at an appropriate time if concerted effort becomes necessary to impact unwise proposals "if such becomes necessary." The Committee recommends that members of the NMA seek increased involvement in HSA activities and task forces.

Respectfully submitted,
C. J. CORNELIUS, JR., M.D.
Chairman

REPORT OF THE MATERNAL AND CHILD HEALTH COMMITTEE

William L. Rumbolz, M.D., Omaha, Chairman; Warren G. Bosley, M.D., Grand Island, Co-Chairman; Dale W. Ebers, M.D., Lincoln; Charles A. Field, M.D., Omaha; L. Palmer Johnson, M.D., Lincoln; Samuel E. Moessner, M.D., Fremont; Bernie D. Taylor, M.D., North Platte.

The Maternal and Child Health Committee met on two occasions during the past year. Three items occupied most of the committee's discussion.

First, a Maternal Mortality Review for 1977 was presented, indicating five maternal deaths during the past year. Two were considered direct obstetric deaths, two were indirect obstetric deaths and one was non-obstetric. Questionnaires were returned on three of the above deaths, but not returned on two; one direct obstetric and one indirect obstetric death. It is hoped that subsequent years will decrease the number of none replies, through the personal contact of the attending physician, of maternal deaths.

Proposed legislation in the realm of the Maternal and Child Health Committee was discussed by the committee and suggestions made as to the recommendations concerning current proposed legislation.

Finally, it is recommended by the committee that a review of perinatal and fetal deaths be carried out by the Maternal and Child Health Committee or its successor in cooperation with the Nebraska Perinatal Organization and other interested organizations. It is proposed that a questionnaire be sent to the attending physician in the case of perinatal or fetal deaths. The questionnaire will be designed to give pertinent information about the antenatal, intrapartum and postpartum periods in addition to information about the neonate. The questionnaire will be constructed to utilize a computer in analyzing information and generating periodic reports. (Attached to this report is a copy of a model/proposed perinatal mortality questionnaire.) To this end, the following resolution is proposed:

RESOLUTION

WHEREAS, perinatal and fetal deaths account for over four hundred deaths a year in Nebraska; be it

RESOLVED, that the appropriate NMA committee study these infant deaths, using a questionnaire to be completed by the attending physician.

Respectfully submitted,
WILLIAM L. RUMBOLZ, M.D.
Chairman

FETAL DEATH RATE:

Number of fetal deaths per thousand total births.

PERINATAL DEATH RATE:

Number of perinatal deaths per thousand total births.

NEONATAL DEATH RATE:

Number of neonatal deaths per thousand live births.

MATERNAL DEATH:

The death of any woman from any cause while pregnant or within 42 days of termination of pregnancy, irrespective of the duration or the site of pregnancy.

1. **Direct maternal death** is an obstetric death resulting from obstetric complications of the pregnancy state, labor or puerperium, from interventions, omissions, incorrect treatment or chain of events resulting from any of the above.

2. **Indirect Maternal death** is an obstetric death resulting from previously existing disease or disease that developed during pregnancy, labor or puerperium; it

is not directly due to obstetric causes, but aggravated by the physiologic effects of pregnancy.

3. **Non-maternal death** is an obstetric death resulting from accidental or incidental causes not related to the pregnancy or its management.

MATERNAL DEATH RATE:

The number of maternal deaths (direct, indirect or non-maternal) per hundred thousand terminated pregnancies.

PERINATAL MORTALITY QUESTIONNAIRE

Definition:

Perinatal Mortality /1000 births
Liveborn dying within 28 days
Stillborns
Weight of 500 gms or more

Mother:

Hospital: Unit #:
Age: Race Marital Status: Parity:
(If abortions, note
spontaneous vs. induced.)

LMP: EDC: Blood type: Rh: Antibody Screen:

HI Titer:

No. Prenatal Visits: Date of First Prenatal Visit:
Avg. BP Highest BP

Weight gain: Blood Pressure during Pregnancy:

Ave Hgb: FHT 1st heard by Fetoscope (not augmented):

Quickening:

Medications during Pregnancy:

Abnormal Medical Hx:

Abnormal Physical Findings:

Pregnancy Complications:

Referred: yes no Hospital: From: To:

Onset of Labor: (date) (time) (spontaneous) (induced)
(please check one)

Oxytocin & Route

Rupture of Membranes: (date) (time)
(spontaneous) (artificial) (please check one)

Color of fluid: Amount ↑ ↓ Normal

Length of Labor:

Total: First Stage: Second Stage: Third Stage:

Monitoring:

Internal: External: Predominant Pattern:

Delivery: vaginal spontaneous

Date: Time: Mode: (check one)

Forceps: (low or mid)

Indication:

Breech (type): Spontaneous, Assist or Extraction:

Forceps to after coming head?:

C-Section: (repeat) (primary) (check one)

Type and Indication:

Anesthesia: General Conduction Local None

Baby:

Hospital: Unit #:

Apgar: 1 min. 5 min. Sex:

Resuscitation: O₂ Bulb Intubation (circle one)

Congenital Anomaly:

Blood Type: Rh: Coombs:

Neonatal Deaths:

Time: Date:

Neonatal Complication:

1.

Rx:

2.

Rx:

3.

Rx:

Causes of Death:
Autopsy (yes or no):
Results:

Intrauterine Demise (complete this section)
Date suspected: Date documented: How:
Suspected Etiology:
Diagnosis of delivery:
Autopsy (yes or no); Results:

Stillborns:
Date and time of demise:
Clinical diagnosis of etiology:
Etiology at delivery:
Autopsy (yes or no); Results:

Summary:

REPORT OF THE MEDICAL EDUCATION COMMITTEE

John W. Smith, M.D., Omaha, Chairman; Wendell L. Fairbanks, M.D., Alliance; Andrew Hahn, M.D., Omaha; Joseph M. Holthaus, M.D., Omaha; Leonard R. Lee, M.D., Lincoln; Perry G. Rigby, M.D., Omaha; Fred J. Rutt, M.D., Hastings; Robert J. Stein, M.D., Lincoln; Larry F. Wilson, M.D., Gothenburg; Paul R. Young, M.D., Omaha.

At its last session, the House of Delegates referred to this committee a resolution requesting the committee study the impact of LB 317, as approved by the Legislature and signed into law in April, 1977, on medical education.

This statute states: Section I — if any vacancy occurs in the enrollment of the University of Nebraska College of Medicine in the first two years of study, such vacancies shall be offered to a student attending an out-of-state or foreign medical school, who: 1) was a Nebraska resident immediately prior to enrollment in such out-of-state or foreign medical school, 2) has completed at least two years of study in such out-of-state or foreign medical school, and 3) has passed Part I of the National Board of Medical Examiners Examination or a comparable examination. Section II — Any individual seeking admission to the College of Medicine pursuant to Section I of this Act, shall meet any requirements that may be prescribed by the Board of Regents.

The committee studied this matter and found one student has entered the University of Nebraska College of Medicine under the provisions of this law. It was found this particular student might well have been admitted to the school without the law by meeting the University's routine admission requirements. The committee determined this law is an unnecessary interference in the admissions policies of the University of Nebraska College of Medicine and recommends that NMA establish the position that this statute should be repealed. The federal law requiring that U.S. medical schools reserve places for U.S. students transferring from foreign medical schools was repealed by the Congress.

The House of Delegates also directed the Medical Education Committee report at this session on a policy for the members of the Association regarding continuing medical education. This matter was discussed in detail, noting there are studies underway regarding the benefits of continuing medical education, including such things as the comparative value of the various types of educational endeavors. The committee recommends there be no continuing medical education requirements established for NMA membership.

Committee members have represented the Association at meetings of the National Council of State Committees of Continuing Medical Education. The efforts of this newly established organization may well produce recognizable benefits in the future. The NMA House of Delegates acted to support this organization at its last session, and the committee would recommend continued Association participation in this organization.

The committee has provided survey teams to visit and review applications for institutional CME accreditation submitted by three Nebraska hospitals. These institutions were surveyed and recommended for accreditation by the Medical Education Committee and the Association's Policy Committee. The recommendations have been submitted to the LCCME for approval.

The CME tabulation form and an informational booklet were recently distributed to Association members. NMA members have an increasing interest in continuing medical education and tabulation of the various efforts in which they take part.

The Medical Education Committee submits this report to the House of Delegates for its consideration.

Respectfully submitted,
JOHN W. SMITH, M.D.
Chairman

REPORT OF THE MEDICINE AND RELIGION COMMITTEE

Edward A. Holyoke, Jr., M.D., Ogallala, Chairman; Kenneth C. Bagby, M.D., Blair; John C. Goldner, M.D., Omaha; James C. Maly, M.D., Fullerton; Byron B. Oberst, M.D., Omaha.

The Medicine and Religion Committee has been inactive for the year. We are continuing, however, to sponsor the annual Medicine and Religion Dinners at the Spring session of the Association. The Annual Recognition of Fifty Year Practitioners will also be accomplished at these sessions.

Respectfully submitted,
EDWARD A. HOLYOKE, JR., M.D.
Chairman

REPORT OF THE MENTAL HEALTH AND MENTAL RETARDATION COMMITTEE

Charles W. Landgraf, Jr., M.D., Hastings, Chairman; John D. Baldwin, M.D., Lincoln; Merrill T. Eaton, M.D., Omaha; Emmet Kenney, M.D., Omaha; Thomas B. Murray, M.D., Kearney; Robert G. Osborne, M.D., Lincoln.

The Mental Health and Mental Retardation Committee has met infrequently during the year and concerned itself primarily with legislation and within its purview.

Specifically we took no position of opposition to LB 380, providing for certification of clinical psychologists, and this was approved by the Legislature. LB 501 provided for two physicians' certification for admission to mental hospitals, and this was supported and approved by the Legislature. LB 554 re-defined sexual offense and provided for hearing and this remains on general file and has not been opposed by the Committee.

In connection with LB 623, the "protection from domestic abuse act," we had some reservations but did

not formally oppose the act and it was approved by the Legislature.

The Committee did register opposition to LB 740 concerning school psychologists and registering such professionals, and the bill was killed by Committee.

Presently under consideration by the Committee are two matters, (1) A document created by the attorney for the Department of Institutions concerning the rights of the mentally ill and mentally disabled, specifically the rights of those suffering primarily from mental illness and those suffering from mental retardation, and (2) Rules and regulations also created by the attorney for the Department of Institutions with regard to medications and their use. Asking consideration of these two matters by the Committee was believed appropriate since they will have an undoubted and marked effect on the practice of psychiatry in the state institutions, and may well later on be used to develop rules and regulations which may effect the private practice of psychiatry in the State of Nebraska. The Committee has already expressed some serious reservations concerning certain portions of these various rules and regulations but its report is not in final form.

The Chairman wishes to commend the members of the Committee for their diligent and thoughtful pursuit of their responsibilities.

Respectfully submitted,
CHARLES W. LANDGRAF, JR., M.D.
Chairman

REPORT OF THE PUBLIC RELATIONS COMMITTEE

Craig R. Nolte, M.D., Lincoln, Chairman; Richard D. Gentry, M.D., Falls City; John E. Hansen, Jr., M.D., Wahoo; Karl F. Niehaus, M.D., Omaha; Joseph C. Scott, M.D., Omaha; John C. Wilcox, M.D., Aurora.

While continuing the activity of providing announcements and column material to Nebraska media, the committee instituted a new project.

In an effort to place both educational and socioeconomic information produced by the Association in the hands of Nebraskans, billing statement inserts were produced. The inserts produced thus far have covered the subjects of proper immunizations, Medicaid waste by government, colds, public attitude on National Health Insurance, weight loss, medical advances and their relation to costs, and treatment mechanisms which have eliminated disease.

Each insert has been made available to NMA members at cost thru the Association newsletter. The orders from members have increased each month.

The third insert carried a small questionnaire requesting the recipients response to the inclusion of the inserts. The public's response was highly favorable. They found the educational items of value, the socioeconomic subjects interesting, and suggested the project be continued.

A press conference was held to announce the formation of the Ad-Hoc Committee on Cost Containment. Participation and coverage by the media was very good.

The committee has also discussed the development of a self-help or self-maintenance program for the public.

Public relations counsel is formulating a pilot project on this subject for the consideration of the Association.

Respectfully submitted,
CRAIG R. NOLTE, M.D.
Chairman

REPORT OF THE EMERGENCY MEDICAL SERVICE COMMITTEE

Richard B. Svehla, M.D., Omaha, Chairman; Anthony J. Carnazzo, M.D., Omaha; Stephen W. Carveth, M.D., Lincoln; Harris B. Graves, M.D., Elkhorn; Andris Matisons, M.D., Lincoln; Dean A. McGee, M.D., Omaha.

The Emergency Medical Service Committee of the Nebraska Medical Association has met on several occasions to better understand and review the multiple emergency medical service activities being conducted in the state. It is the feeling of the committee that the membership of the NMA should be well informed of these related projects and continue to extend their advice and guidance for the best welfare of the citizens of Nebraska.

Specific recommendations for all groups and agencies active in Nebraska's emergency medical service program are made as follows:

1. Encourage the teaching and participation in the programs for C.P.R.
2. Help promote better rapid transport of critical patients especially in rural areas by such means as fixed-wing aircraft or helicopters.
3. Encourage the enlargement of the communications system.
4. Need to establish an ongoing line of communications between the State Health Department, the various EMS councils and the NMA.
5. Alert hospitals and their medical staff of the anticipated emergency room categorization and classification.

Respectfully submitted,
RICHARD B. SVEHLA, M.D.
Chairman

REPORT OF THE MEDICOLEGAL ADVICE COMMITTEE

James H. Dunlap, M.D., Norfolk, Chairman; Hiram Walker, M.D., Kearney; John P. Gilligan, M.D., Nebraska City; Arnold W. Lempka, M.D., Omaha; Houtz G. Steenburg, M.D., Aurora.

Your Medicolegal Advice Committee has met via a telephone conference call on a single occasion since the last meeting of the House of Delegates. In addition, numerous affairs have been conducted outside of a committee setting.

The activities of this committee have been in five areas:

1. We have published and mailed to all members of the Association a brochure entitled, "The Physician and Professional Liability." Further copies of this brochure are being distributed to physicians as we become aware of potential or actual individual instances of litigation.
2. We are in a position to lend assistance in the instances of litigious claims both to individual physicians and individual professional liability underwriters. This is the largest area of committee activity and because of the delicate nature of circum-

stances in most of these cases, has been handled by the committee chairman.

3. We are monitoring the activities of the one professional liability countersuit which appears now to be scheduled for court in the immediate future.
4. We are attempting to develop with the principle underwriter in Nebraska new liaison in discovery of individual cases of litigation so that we can be of increased help both to the accused physician and to his insurance carrier.
5. Your attention is called to a recent letter from our committee distributed via the pink sheet advising physicians to become better acquainted with "claims made" and its ramifications. In at least one instance a Nebraska physician may be in jeopardy because of inadequate coverage when he changed from one claims made policy to another company which also issued claims made insurance. In this instance an inadequate "tail end" coverage existed from his original company.

Respectfully submitted,
JAMES H. DUNLAP, M.D.
Chairman

Pink Sheet Letter

March 30, 1978

Dear Doctor:

A recent situation in Nebraska makes the information in this letter very important.

If you have a professional liability (malpractice) insurance policy on a "claims-made" basis and decide to change companies, review your coverage situation carefully. Some policies written by the St. Paul Fire and Marine (the NMA sponsored carrier), Lloyds of London and the Mutual Fire, Marine and Inland Insurance Company (the AAPS sponsored carrier) may be examples of policies which may be "claims made" to various degrees.

These types of policies may require certain extensions be purchased or options exercised to provide adequate coverage should a suit be brought after you have left a company.

If you consider leaving a "claims made" policy, or changing from one "claims-made" policy to another, be certain your insurance agent or personal attorney has reviewed your situation and provided written assurance that you are adequately covered for prior incidents which may subsequently arise.

Cordially,
s/ James H. Dunlap, M.D.
James H. Dunlap, M.D., Chairman
Medicolegal Advice Committee

REPORT OF THE MEDICAL SERVICE COMMITTEE

Blaine Y. Roffman, M.D., Omaha, Chairman; **Legislative Subcommittee:** Robert F. Shapiro, M.D., Lincoln, Co-Chm.; Howard A. Dinsdale, M.D., Lincoln; Thomas G. Erickson, M.D., Fremont; Donald F. Prince, M.D., Minden; Harold R. Horn, M.D., Lincoln; Eugene M. Zweiback, M.D., Omaha. **Medical Liability Subcommittee:** Herbert E. Reese, M.D., Lincoln, Co-Chm.; August H. Bergman, M.D., Fremont; Warren G. Wooley, M.D., Grand Island; James H. Dunlap, M.D., Norfolk; Dwaine J. Pappas, M.D., Neligh; A. L. Smith, Jr., M.D., Lincoln.

Medical Liability Subcommittee

The Medical Liability Subcommittee has no formal

action this year. The activity simply consisted of monitoring legislative activities regarding medical liability and the Department of Insurance and its implementation of the Act.

Legislative Subcommittee

The short 60-working days session of the Nebraska Unicameral this year allows the Legislative Subcommittee to submit its report in a more timely fashion than has been the case in past years. After our introductory comments, we will include the customary composite list of the legislative bills introduced in this session or carried over from last year which had pertinence to medicine and where or how they ultimately ended up in the legislative process.

As is frequently the case it appears that a majority of the bills which advanced from the committees to general file will die without any further action being taken. These bills will not be carried over to the next legislative session which is in contrast to the situation last year where bills were carried forward from the 90-day to the 60-day session.

There were only a few bills this year which were of keen importance to us. These involve optometry and certificate of need legislation. A bill which required mandatory autopsies in the case of victims of the Sudden Death in Infancy syndrome did make it through the Legislature and was signed by the Governor. The optometry bill was fiercely opposed by our ophthalmologists colleagues as well as the NMA. The bill is on general file and it appears that because of time limitation that it will not be advanced this session. The rather complicated and controversial certificate of need bill will not be acted upon this session. However, it represented landmark legislation for several reasons.

The most important aspect of the certificate of need bill from our viewpoint related to the fact that the Nebraska Medical Association and the Nebraska Hospital Association worked closely together in developing this piece of legislation which, keeping in mind everybody's disdain for this type of legislation in general, was at least considered to be the least unacceptable piece of legislation to both groups. The two groups also agreed to hang together if their "jugal issues" were compromised. To get this piece of legislation introduced was a difficult task and it was necessary to get this bill substituted for a similar bill which had many more unacceptable provisions. The bill was basically authored by the Hospital Association with the Medical Association providing advice and counsel.

Even with close liaison late in the process, numerous technical problems in the bill were discovered and yet it was hoped that this legislation could be passed with the hope of improving it later. This concern related to the fact that this type of legislation is mandated by the Federal Government and it was felt that there might be even greater difficulty in dealing with a future legislature in regard to this type of bill. There is no doubt that we can expect to see it again next year.

The bills pertaining to medicine are as follows and the outcome as noted:

LB 575 — Adds a hospital administrator to the State Board of Health. Approved by the Legislature.

LB 595 — This legislative proposal would alter Nebraska law to allow optometrists to use eye drugs. Indefinitely postponed.

LB 605 — Relating to Sudden Infant Death Syndrome; to provide for an autopsy in certain cases. Approved by the Legislature.

- LB 623 — To adopt the Protection From Domestic Abuse Act. Approved by the Legislature.
- LB 669 — Increase the number of students entering the Physician's Assistant Program at the University of Nebraska Medical Center. Indefinitely postponed.
- LB 671 — Provides for recording paternity data on birth certificate. Approved by the Legislature.
- LB 737 — Requires rubella vaccination for women getting married. Approved by the Legislature.
- LB 738 — Establishes a Nebraska Computer Privacy Act. Indefinitely postponed.
- LB 740 — Register school psychologists. Indefinitely postponed.
- LB 761 — Provide for foreign medical graduates to obtain license to practice medicine. Approved by the Legislature.
- LB 778 — Authorize manufacture and sale of laetrile. Indefinitely postponed.
- LB 786 — Provide for rules of operation for HMOs. Approved as amended.
- LB 794 — Provide requirements for persons working with radiation. On General File.
- LB 795 — Provide for filing certificate of need for health care facilities. Indefinitely postponed.
- LB 844 — Allow additional credentials for medical practice. Indefinitely postponed.
- LB 853 — Require optometrists to refer to physician persons with eye disease. Indefinitely postponed.
- LB 884 — Establishes medical student loan program. Approved by the Legislature.

Next year's Legislature and the legislation itself will present ever increasing challenge to all of us as physicians.

It seems that each election period the average age of the Senators decreases somewhat and there appears to be a more liberal tendency developing within the Legislature. In addition a more active role is being demonstrated by the legislative staff which adds a new dimension to our legislative activity.

This, of necessity, means that we will have to redouble our efforts in order to remain as effective as we have been in the past in getting our feelings acknowledged.

In the future the types of legislation, if the track record in other states would be extended to Nebraska, may include such things as hospital rate control, physician rate control, physician relicensure, HMO's, and of course, the certificate of need type of legislation.

Respectfully submitted,
BLAINE Y. ROFFMAN, M.D.
Chairman

REPORT OF THE AD-HOC COMMITTEE ON COST CONTAINMENT

Craig R. Nolte, M.D., Lincoln, Chairman; Richard D. Gentry, M.D., Falls City; John Hansen, M.D., Wahoo; Karl Niehaus, M.D., Omaha; Joseph C. Scott, M.D., Omaha; John C. Wilcox, M.D., Aurora.

The ad-hoc committee was appointed by Doctor Lempka in January of 1978, for the purpose of studying the cost of medical care and forming suggestions for Association consideration. The considerations include review both of publications of the AMA National

Commission on the Cost of Medical Care and of multiple state and regional agency studies of this same situation. Aware that great public interest has been generated in this area, and that a great deal of study has been performed as regards the factors which produce high cost in medical care, committee efforts were directed toward issues primarily of local relevance. It was felt that Nebraska Medical Association members could indeed achieve greater awareness of cost and possibly greater control of future cost generations in a number of ways as outlined in the following paragraphs:

(1) The committee feels that major efforts should be continued to direct education both to members of the Nebraska Medical Association and to physicians in training in the State of Nebraska concerning cost consciousness. In that vein, it is strongly suggested that the House of Delegates reconsider their position concerning medical school courses and curriculum additions based on physician-generated medical costs. This could take the form of didactic courses subject to examination, but at least should include awareness of such information both from the hospitals, from the preceptors, and from the medical school faculties.

In addition, to foster NMA physician education in cost containment, member physicians should attempt to make themselves specifically aware of the costs that they generate, both through their offices and through their hospitals. Hospitals should make an effort to inform doctors of both average and unusual patient charges on a fairly regular basis. In addition, hospital audit and utilization committees should consider periodic reviews of both routine and special-procedure costs. These should not interfere with a proper assessment of quality of medical care. Dialogue with hospital associations and administrators should be continued regarding ways in which staff physicians may be made more aware of the costs they generate and of areas in which these costs may be inhibited.

(2) Patient education is felt to play a major role in the subject of cost containment through the Medical Association. Patients, i.e., "consumers," should be made acutely aware of ways in which medical care costs are driven upward. Consumers should be aware that costs are generated regardless of who reimburses those costs. Self-care, preventive medicine, and improvement of life-style and habit-patterns, all are quite relevant in the overall generation of medical costs. We must encourage the public through our strongest personal and public relations contacts to be acutely aware of the economies of medical care. Suggestions have included limitation of emergency and hospital care to true necessity, and the education of the patient in regard to his alternatives to these expensive modes of care.

(3) Careful attention must be paid to the tremendous cost generation of the third-party-pay system. Both physicians and patients become less and less aware of high costs as more intermediaries are injected into the reimbursement systems. The practice of first-dollar coverage for all in-hospital and emergency medical care and the absence of co-insurance should be reviewed. All further additions of parties to handle medical reimbursement will generate greater cost. For that reason, governmental supervision and agency review can be only seen to duplicate and increase the overall expense. The public must be aware of the savings that could possibly be accrued from less-than-total coverage and from removal of the first-dollar payment system.

In like manner, the alteration of or infringement of the physician-patient relationship from many other outside sources should be reviewed. The practice of

defensive medicine is prevalent, and is fostered by undue access to compensation for exclusions of tests and not for damages or injuries sustained. The loss of confrontation of the patient by the doctor and the loss of responsibility for the medical bill are also results of third and fourth party payment programs.

(4) The combination of medical facilities and the consolidation of overlapping facilities whenever possible is a factor in future containment of medical costs. Local societies and hospital staffs are encouraged to look into this factor wherever relevant. Unnecessary competition or duplication is discouraged where no obvious patient benefit will result.

In the State of Nebraska, training programs should continue to be directed toward the production of primary care physicians and the placement of these physicians in areas of need. The use of physician extenders and paramedical personnel should be considered primarily to improve care in areas where physician capabilities are limited or overstrained.

(5) Outside influences on the doctor-patient relationship should be vigorously opposed when they tend to also increase the cost of medical care. Unnecessary regulatory intrusions have not been proven to be cost effective, and influences such as PSRO or multiple-agency evaluations of hospitals, etc., tend to overlap each other and greatly increase the cost that the government and the consumer are therefore required to place into the medical care system. Over-utilization, improper utilization and improper hospital use, unneeded use of emergency and ambulance services, unnecessary second opinions and requirements for repetition of basic care should all be discouraged wherever possible. Local insurance premiums should be based on state or local experience and providers should be strongly encouraged to allow Nebraska the benefit of its generally lower hospital costs. These savings should be passed on to the consumer. Hidden costs, equipment, inflation, minimum wage increases, interest rates, and more and more severe minimum standards for hospital care, all directly contribute to costs.

It was the opinion of this committee that cost consciousness is indeed a laudable goal. Optimal medical care and maximum benefits of medical services, however, are the basic concerns of the Nebraska physician. Cost containment, therefore, should be a matter of consciousness and consideration and should not be a goal to be fostered by any organizations to the point of infringement on optimal medical care.

Respectfully submitted,
CRAIG R. NOLTE, M.D.
Chairman

REPORT OF THE POLICY COMMITTEE

Arnold W. Lempka, M.D., Omaha, Chairman; Harlan L. Papenfuss, M.D., Lincoln; Warren G. Bosley, M.D., Grand Island; Houtz G. Steenburg, M.D., Aurora; James H. Dunlap, M.D., Norfolk

The Policy Committee has had six meetings in the interim since the Fall, 1977 Session of the House of Delegates. The committee presents the following report to the House of Delegates.

The committee recommended Doctor Paul E. Collicott of Lincoln be appointed to the Board of Examiners in Medicine and Surgery. The recommendation was also made to the Board of Health and Doctor Collicott was appointed.

2. Appointments to the Commission on Medical Qualifications as established by the passage of LB 434 was considered. This is a five-man commission, with the Governor selecting one physician, the Board of Examiners selecting two physicians and the NMA selecting two physicians. The Policy Committee selected Doctor Warren R. Miller, Columbus and Doctor Herbert E. Reese, Lincoln.

3. Appointments were made to the Disabled Physicians Committee.

4. The Policy Committee considered the selection of the Ad-Hoc Committee on Cost Containment and the appointments were made in November of last year.

5. The Policy Committee reviewed the new NMA life membership requirements and directed that copies be sent all county medical societies with the recommendation that county medical society articles and by-laws be appropriately amended to reflect the new requirements for this category of membership.

6. The AMA requested a reaction to its presenting a CME program in Lincoln or Omaha. The Policy Committee accepted the AMA's offer to present such a program.

7. The Policy Committee met with Doctor Roger D. Mason, Medical Director of Blue Cross-Blue Shield of Nebraska at which time he reported Northwestern Bell Telephone Company had renegotiated a continuation of its health insurance benefits which include a provision for "second opinion surgery" for its employees. Following discussion, the Policy Committee accepted Doctor Mason's written and oral comments for informational purposes.

8. The Policy Committee considered in detail the matter of certificate-of-need legislation which was developed for and ultimately introduced in the 1978 session of the Legislature. The committee voted to support and endorse the Nebraska Hospital Association's proposed certificate-of-need legislation contingent upon several features which of necessity we felt had to be provided for in the legislation. The Medical Service Committee's Report will provide information on the eventual status of the legislation.

9. The committee was informed that an optometric bill would be introduced into the Legislature to allow that group to use certain eye medications. The Policy Committee directed the Nebraska Academy of Ophthalmology be requested to keep the NMA apprised of all legislative activities in the area of ophthalmology so that a cooperative effort could be utilized.

10. The committee discussed the possibility that there might be legislation considered for introduction which would give prescription rights, etc., to physician's assistants. The committee established a position of opposition to such legislation.

11. The Policy Committee considered and approved the site survey team reports and accompanying recommendations for CME accreditation for Childrens Memorial Hospital in Omaha, The Lutheran Medical Center in Omaha and Mary Lanning Memorial Hospital in Hastings. These recommendations for accreditation were then forwarded to the Liaison Committee on Continuing Medical Education (LCCME).

12. At the request of the NMA Auxiliary, an advisory/review committee was selected to provide medical input into the development of the exhibitory of the Health Galleries. The committee will review the proposed designs and concepts to determine if they are medically accurate and possibly develop specific guide-

lines which should be followed in the development of exhibits and also provide the Health Galleries Steering Committee with certain directives. Selected to this committee were Doctor and Mrs. Clyde L. Kleager, Hastings and Doctor Marvin Holsclaw of Lincoln.

13. The committee monitored closely the activities regarding the proposed hospital regulations and standards as being proposed by the Department of Health. Several meetings were held with Department of Health representatives and representatives of the Nebraska Hospital Association in an effort to provide input which would result in a document appropriate for and workable in the State of Nebraska. At the writing of this report, the finalized draft of the regulations and standards has not been accepted by the Department of Health however we expect the Board of Health to consider this matter in the very near future.

14. The Association has been approached by the Rocky Mountain states' medical associations with an invitation to join their multi-state physician purchasing service currently being developed. A purchasing survey showing comparative prices and background on the development of the joint purchasing program are attached to this report. The committee would recommend that a reference committee of the House of Delegates consider this matter in detail, and further, the committee recommends the House endorse participation in the program and authorize the Board of Directors to negotiate and finalize arrangements for the Association's participation in this effort. The voluntary participation effort by the Western Physician Purchasing Association can truly become a membership service. The physician can achieve considerable savings through participation in this effort.

15. The committee met with representatives of the House Officers' Associations from the University of Nebraska College of Medicine and Creighton University School of Medicine. The committee was happy to receive the information from the representatives which would indicate that a cooperative effort has now replaced the litigation approach taken to resolve disagreements between the residents and the University of Nebraska Medical Center. The Policy Committee is optimistic and hopeful that such an approach will lead to a more cooperative and productive relationship and provide the appropriate vehicle to resolve future differences. It is the recommendation of the Policy Committee that an appropriate body of this Association would monitor any future disagreements between house officers and the Medical Centers and assume an appropriate posture based upon the individual situation as it arises and that there would be continued input and participation of the house officers on all matters of mutual interest.

Respectfully submitted,
ARNOLD W. LEMPKA, M.D.
Chairman

REPORT OF THE AD-HOC LIAISON COMMITTEE WITH STATE GOVERNMENTAL AGENCIES

Warren G. Bosley, M.D., Grand Island, Chairman; James R. Adwers, M.D., Omaha; Charles M. Bressman, M.D., Omaha; John F. Fitzgibbons, M.D., Omaha; Donald E. Matthews, M.D., Lincoln; John G. Yost, M.D., Hastings.

The ad-hoc committee has had no formal meeting since its last report in October, 1977, however liaison has continued on a regular basis with various agencies

of state government whose functions and activities involve the concerns and interests of the Association.

The Chairman of the ad-hoc committee has been appointed by the Governor to the State Board of Health which permits a very close liaison with this agency and an opportunity to express the concerns of the Association at official and unofficial levels. Together with other members of this Association, the Chairman of this ad-hoc committee has been able to interpret to the Board of Health the Association's ideas about changes in rules and regulations for hospitals in Nebraska. It has also been possible to maintain close contact with the activities of the Department in the fields of maternal and child health, vital statistics and crippled children's services.

Within the constraints imposed upon the Department of Public Welfare by the Department of HEW, it has been possible to work closely and cooperatively with that Department. Within these constraints, there appears to be a very good understanding by the Department of the wishes and aims of the Nebraska Medical Association, together with a wish to respond to them in the policies of the Department. The Department has often asked the Association for support in resisting and modifying certain policies and directives of the Department of HEW that appear not to be in the best interest of the people and physicians of Nebraska. There continues to be a close exchange of ideas and a responsiveness which is seen in few, if any, other states.

During the last several months, it has been possible also to develop good communication with the State Department of Education. The Chairman of the ad-hoc committee participated in a meeting concerned with mandatory physical examinations for school children at intervals during their school career. This meeting involved representatives of the Department, the Nebraska State Education Association, the Nebraska State School Boards Association, the Nebraska School Activities Association, and others concerned with this kind of examination. A consensus of this meeting appeared to be that it was sufficient to have such evaluations required by law only at entrance to school, at the kindergarten level, with other examinations recommended at appropriate times by the Department. There appeared to be general agreement that further laws in this regard were not necessary or advisable. With the increasing involvement of the State Department of Education in matters relating to health, increased communication with the State Department of Education should be developed. PL 94-142, which relates to educationally handicapped individuals, defines one area in which the medical professional should become more involved. Although the law minimizes the role of physicians in the evaluation of handicapped individuals and programs developed for them, the Department appears to be interested in responding to medical input. I believe the Association must continue to urge its active participation in these programs of evaluation. The physician remains the best advocate of the handicapped child or adult and we must insist on this position of advocacy.

Perhaps it is incidental to this report that the Chairman of this ad-hoc committee has been made a member of the Council on Pediatric Practice of the American Academy of Pediatrics. This permits an insight into national health policy and the activities of various federal agencies, which insight can and will be made available to the Association at all times.

In the reorganization of the Nebraska Medical

Association, this ad-hoc committee recommends consideration be given to continuing some official liaison with agencies of state government. These agencies appear to appreciate the opportunity to discuss their problems and policies with the Association, and I believe we must take advantage of this opportunity and interest. Whether we like it or not, the future of our patterns of practice appear to lie in bureaucracy and politics.

Respectfully submitted,
WARREN G. BOSLEY, M.D.
Chairman

REPORT OF THE CONSTITUTION AND BY LAWS COMMITTEE

J. P. Schlichtemier, M.D., Omaha, Chairman; James G. Carlson, M.D., Verdigré, R. L. Cassel, M.D., Fairbury; Earl J. Dean, M.D., Hastings; Donald A. Dynek, M.D., Lincoln; Harvey Konigsberg, M.D., Omaha; Harold M. Nordlund, M.D., York.

Since the meeting of the House of Delegates last fall, modifications in the proposed Articles and By-Laws have been made accordingly with the instructions of the House. In addition, the document has been resubmitted to legal counsel for a final determination, and staff has reviewed the modified document. Only a few minor modifications have been suggested to clarify certain sections, but none of these changes modify the intent of the several sections.

Therefore, a final draft copy of the Articles and By-Laws incorporating the suggested changes are submitted at this time for action by the House. The Committee recommends that the House adopt the Articles and By-Laws as submitted with this report.

Respectfully submitted,
J. P. SCHLICHTEMIER, M.D.
Chairman

REPORT OF THE AD-HOC COMMITTEE ON FEDERAL LEGISLATION

Jerald R. Schenken, M.D., Omaha, Chairman; C. J. Cornelius, Jr., M.D., Sidney; Louis J. Gogela, M.D., Lincoln; Harold R. Horn, M.D., Lincoln; Donald F. Prince, M.D., Minden; Gerald J. Spethman, M.D., Lincoln.

The Ad-Hoc Committee has reviewed several items which are extremely important to the medical profession.

National Health Insurance: Proposals for national health insurance appear to be receiving renewed interest in Washington after a short period of inactivity. The exact makeup of these proposals and which one if any that will receive the most consideration is not clear at this time. The Committee plans to monitor carefully all proposals relative to national health insurance.

Action:

The Committee recommends that the Nebraska Medical Association reaffirm its previous position opposing compulsory national health insurance and opposing AMA sponsorship of bills proposing national health insurance such as HR 1818 and S 218.

Action:

The Committee recommends that the Nebraska Medical Association reaffirm its position opposing the Nebraska Medical Association as an organization assuming a participatory role in the federal program of PSRO for Nebraska.

HMOs: Several proposals have been introduced in Congress to modify the conditions under which HMOs may be established and operated as well as the relationship between HMOs, government, third-party payors, and patients. The American Medical Association which has supported an experimental approach to evaluation of HMOs as an option for care and a pluralistic health delivery system, has testified to this effect before the Subcommittee on Health and Scientific Research of the Senate Human Resources Committee. The Committee is opposed to continuing federal subsidies for HMOs, to changing their benefit and enrollment policies making them less consistent with the requirements of complete patient care, to granting them special loans and loan guarantees not available to other sections of the medical/health care system, and to exclude them from provisions of the Health Planning Act applicable to other "competing" physicians and/or institutions.

Action:

The Committee recommends that the Nebraska Medical Association support the American Medical Association's experimental approach to the development of HMOs, recognizing them as one of many possible alternative methods for the provision of medical care to patients, but one which should be subjected to clinical experimental review and evaluation before widespread implementation. The viability of the HMO concept should be proven without government subsidy, with open enrollment, without selective exclusion from health planning restrictions, and without restrictions on benefits which would alter its competitive nature.

Cost Containment: The Committee discussed numerous cost-containment proposals including those presently being reviewed in the House Ways and Means Committee and the House Committee on Interstate and Foreign Commerce. Many of the proposals for cost containment appear rigid, arbitrary, and to address symptoms rather than the basic causes for rising costs of medical/health care as an isolated segment of our present inflationary economy.

Action:

The committee recommends that the Nebraska medical Association recommend that any measure proposed for controlling costs of medical care should not compromise quality nor penalize physicians in their efforts to care for their patients.

Health Planning: Several proposals for amendments to the Health Planning Act (PL 93-641) were discussed including S2551 and HR 10640. The American Medical Association has presented comprehensive, critical and appropriate comments on many of these suggestions as well as having made significant positive recommendations for the improvement of these proposals. The Committee is supportive of the American Medical Association's comments opposing extension of Certificate of Need legislation and/or regulations to cover physicians' offices, opposing mandatory programs for decertification of facilities (a section which has been stricken from at least of the proposals), and opposing special consideration for HMOs under health planning laws.

Your Committee plans to continue its surveillance of federal legislation and regulations affecting medicine and make such information as it obtains available to the organization.

Respectfully submitted,
JERALD R. SCHENKEN, M.D.
Chairman

Report of Board of Councilors

The Annual Session meeting of the Board of Councilors was held April 30, 1978, at the Lincoln Hilton, Lincoln, Nebraska.

The meeting was called to order by the Chairman, Dr. Wilson. The following members of the Board of Councilors were present: Doctors Carlyle Wilson, Louis Gogela, H. C. Stewart, James Carlson, Warren Miller, Richard Pitsch, Clarence Zimmer, James Ramsay, Joel Johnson, Fred Rutt, Berl Spencer, Calvin Oba, Arnold Lempka, and Houtz Steenburg. Guests attending were Doctors Carl Cornelius, Dan Nye, and Frank Cole.

The Chairman called for approval of the minutes of the Fall Session meetings as published in the December, 1977, issue of the Nebraska Medical Journal. These were approved as printed.

The Board of Councilors next discussed several problem cases which had come to their attention since the Fall Session meeting.

The Board of Councilors considered the reports and resolutions contained in the Handbook.

In considering the report of the Ad-Hoc Committee on Cost Containment, Dr. Cornelius said he hoped that the committee would take positive action on this, and he thought that physicians should be aware of the hospital bills of their patients. It was the recommendation of the Councilors that a recommendation be made to the House of Delegates that a specific action program in this area be developed by the committee in the very near future. This was approved.

In considering Resolution #1, concerning Medical Ethics, it was the opinion of this body that a recommendation be made to the House of Delegates that our Delegates to the AMA vote for retention of the current Code of Medical Ethics. This was approved.

The Chairman called for approval of the listing of Life Membership requests, and these were approved.

All other reports and resolutions were accepted by the Board of Councilors for consideration of the House of Delegates.

There being no further business, the meeting was adjourned.

Report of House of Delegates

FIRST SESSION

The first session of the session of the House of Delegates was held April 30, 1978, at the Lincoln Hilton Hotel, Lincoln, Nebraska.

The meeting was called to order by the Speaker, Dr. McFadden. Roll call showed 64 delegates present, and the House was declared in session.

The Necrology List was read by Dr. James Dunlap.

The following oral reports were presented:

Mrs. Orin Hayes — Report on Health Galleries

Dr. Neal A. Vanselow — New Chancellor of the University of Nebraska Medical Center

Dr. J. G. Morgan — Representative of the Nebraska Dental Association

Dr. Arnold Lempka, President of the NMA, gave the following report:

Mr. Chairman, delegates, colleagues and guests. At

this time, I have the prerogative of speaking to you in a manner that allows me to express my inner feelings, a no holds barred situation.

This gives me a chance to ramble about any thing that comes to mind.

During the past year, I have tried to limit my expressions to coincide with the sentiments of the Association, but now I can expound freehand.

Never was there a dull moment, always intense activity on all fronts. No sooner was there a resolution on one problem when another would pop up. It has been a pleasure to service a financially sound viable organization that made me feel proud to be one of its members and to serve as its President.

Like Topsy, the Nebraska Medical Association is growing, growing in stature and prominence.

The present offices in the First National Bank Building seemed more than adequate when we first moved in, but now the walls are bulging, the conference room is too small and we need more space.

Plans are being formulated for expansion this next year. The workload of the Association is ever increasing so it is imperative that the office be expanded both in space and personnel. This growth is good.

It is apparent that our Executive Secretary has outgrown his title of Secretary, he is more of an Executive Director in his activities now, and I hope that title change could be accomplished in the near future.

Because of the increase in expenditures due to inflation, the increase in activities and the plans for expansion, the dues were increased this past year. I was particularly pleased by the lack of complaints to the increase in dues. I believe this is a vote of trust in the Association by the members of the Nebraska Medical Association. We still have a bargain in our dues compared to other states and no one should feel the dues are an incentive to keep them out of the society.

My experience this year with the legislators in this state prompts me to say that the senators seek and greatly respect doctors' opinions on legislative matters. They apologize for having to make decisions regarding medical matters and appreciate any information we can give them. It becomes evident to me, the best way to approach them on medical problems is not to call them by phone at a time they are busy and thinking about something else, but to put down your thoughts and opinions in a brief, concise manner on paper which they will file away and retrieve when that particular medical legislation comes up. They even seem to appreciate doctors' opinions on any pending legislation. With that thought in mind, it would seem paramount that we should have a physician in the Legislature as a senator and should work toward that end particularly with the great thrust to medical legislation.

My concern for medical students and young doctors has never been greater than it is now, I have worked, as a private physician with students of medicine all my professional life and saw them, for the most part, unconcerned about the future of medicine which to them always seemed secure. However, the changing political atmosphere mandates that the budding doctor be involved in the planning of his future. He has to learn more, than ever before. Instead of being content with the scientific aspect of medicine he has to now consider the economic, legal and political aspects and it behooves us older ones to see to it that he gets this

exposure early in his career, going so far as to have formal classes in school in these subjects if necessary.

The Woman's Auxiliary is a powerful growing force, eager to work side-by-side, in the political field. They are getting great support in their Health Galleries project which I understand is now 67% funded by our medical community and with the support of the rest of you can easily reach the medical community commitment in this regard. Their constant effort to raise monies for medical schools never ceases. They are a strong ally and need our support and encouragement in their endeavors.

It never ceased to amaze me how if you have something good going someone is always wanting to step in and take it over.

The Joint Commission on Hospital Accreditation is fighting for its life. The government is trying to step in and do for free what the Joint Commission has been doing for years and charging for it. I ask you, what in this world is free? The Joint Commission has been doing a good job — don't be too eager to abandon your support. Don't be too eager to let government step in and do their job. They need your support if you believe in free enterprise.

Speaking of the future, National Health Insurance always seemed so far away. I was led to believe that next year would be the year, but now it appears to be up for consideration in Washington at an early date, maybe later this month with action by Congress before the year is out.

Speaking of government reminds me of cost containment and the government's attack on medical care costs. Medical care costs are being attacked from every angle and in defense we have established a committee on cost containment in our Association. The announcement of its formation was met with great response by the press and the media. They crowded into my little old office so there was barely breathing room. Would that my office would fill up with patients like that.

Nevertheless, the committee was activated, is studying the problem mainly on a local state-wide basis, but is also reviewing the controversial AMA Commission Report. It will be one of the busiest committees of the Association. I hope when they are through, they will have properly placed the blame for escalating medical costs and been effective in their effort of cost awareness.

New forms of health care delivery systems are trying to make inroads into our present system. It is my hope that these will be on a fair, competitive basis. HMOs are being set up on a trial basis with the government subsidizing them by 30%. This is not fair competition and when companies are made, I hope it would be on a free-standing basis and not by the subterfuge supported by government subsidy.

Just a word to the ophthalmologists. Medicine is a great profession, at least it must be because there never ceases to be someone trying to get a piece of the action. This year the pressure from the optometrists was terrific. As you know, they want to do what the ophthalmologists do and I say let them do it, but only after they take the training the ophthalmologist does — namely, get an M.D. degree, not by legislative action which nearly became a fact this year and the problem will not go away. It behooves the medical profession and the ophthalmologist to come up with some positive action in this regard.

Another thing that won't go away is laetrile.

Although discovered some fifty years ago by a California doctor who wanted to find a way to improve bootleg whiskey, it just will not die. Laetrile is a cure for cancer, no that's not right; is a preventative for cancer, no that's not right; is a cause of cancer and that may be right if we are to believe John's Hopkins University. Hours of testimony before the legislative hearings were carried out. The emotional issue completely dominated the scene. I shudder to think how our Legislature may have voted on this issue if it ever had reached the floor of the House and with no scientific proof of efficacy it may have been forced upon us.

If all the money spent for laetrile and against laetrile together with all the time spent arguing the pros and cons were put together in one big research project for cancer, we might have solved the cancer riddle by this time. It is a shame we have to fight by negative action.

The past year has kindled relationships with the Nebraska Hospital Association. Action by the Nebraska Department of Health has brought us closer together than ever before. You may not recall, but nearly two years ago the Department of Health sent out a request for input on new hospital regulations for licensure. Receiving none, the Department of Health set out on its own and came up with new regulations.

They took the old rules, which were 18 pages in length and expanded them to 261 pages. In doing so, they encroached on the physician's right in the practice of medicine and made it impossible for hospitals in rural Nebraska to exist. However, with the combined effort of the Nebraska Hospital Association, the Nebraska Medical Association, together with good cooperation from the Department of Health, we came up with about 75 pages of rules and regulations for licensure of hospitals which for the most part are reasonable and compliable and brings Nebraska up-to-date in hospital rules and regulations which had not been revised for 20 years.

Another area of coordinated effort with the Nebraska Hospital Association was on certificate-of-need legislation sponsored by Senator Richard Lewis. The main thrust of this bill was aimed at the hospital, but originally it included doctors' offices, which was of great concern to us. This bill also failed to reach the floor of the House so I would expect it to be back next year, probably with more restrictions.

Back in 1970, when I was President of my County Medical Society, when PSRO began to sprout and was confused with PRO (Peer Review Organization) a voluntary effort that did and still is serving us well, I fought PSRO at that time and am still fighting it even though, in the interim, it has become law and is mandatory.

We have had quite a year with PSRO with direct correspondence with Washington and frequent visits from the Regional Office in Kansas City with the net result that we are the only state in the Union without PSRO.

We were almost taken in by PSRO when it was first proposed on the basis it was quality control and it would upgrade medical care, but it is obvious now that it is just cost control that may be spending more money than it saves.

The deadline for us to set up a voluntary PSRO was January 1, 1978, but we held fast.

It was very interesting how at the various PSRO meetings people would tell us we should take PSRO.

The University of Nebraska, Creighton University, Nebraska Hospital Association all told us we should get into PSRO, but when the question was turned around and they were asked why they didn't get involved with PSRO they said — Oh! but we don't want it — it wouldn't be good for us to run PSRO.

Others were asked including American College of Surgeons, Nebraska Chapter, the Academy of Family Practice, the pediatricians, they all turned it down. Things were getting desperate, even Welfare turned it down.

Then in February the Blues were asked. They were cautious at the first Board meeting, discussing it and laying it over for a month to study the feasibility and doctor acceptance of the idea they would do us a favor by running it.

At their next Board meeting, one of their most active I am told, the fight against it was led not only by doctors, but the lay members of the Board and it was flatly turned down. That still left Nebraska without PSRO.

Well, where do we stand now? About a month ago, three top men out of the Kansas City Office of HEW visited us. They offered one more chance to get involved with PSRO even though the deadline was last January. Not being favorably received they stated their only recourse now was to print the fact that Nebraska did not have a PSRO in the FEDERAL REGISTER which in essence is their way of advertising for bids for an alternate PSRO in Nebraska. So far, I have not seen the advertisement, and I hope it never appears.

In the meantime, I emlore every doctor in the State of Nebraska to practice the very best medicine possible and to carry on our present voluntary review mechanism, which I feel equals or surpasses any PSRO mechanism the government could set up.

As you know, the Supreme Court ruled the malpractice legislation constitutional last July 10. Because of this legislation, I have enjoyed much popularity during my presidency, getting credit for something I didn't do. The real glory should go to the "Malpractice Five" — Doctors Reese, Papenfuss, Roffman, Bosley and Dunlap, together with Senators Loran Schmit and John DeCamp.

Our successful legislation has been the subject of discussion all over the country and serves as a model for others to follow.

Some 850 physicians are covered along with four hospitals and nine anesthetists. There is room for more, so if you have not joined, you are missing a great opportunity. One doctor told me that the money he is saving because of malpractice laws will pay for his dues to the Nebraska Medical Association for years to come. This should be an incentive for all to join.

Besides the economical umbrella coverage there are benefits to the patient as well as the doctor and I must remind you what has happened to the basic \$100,000-\$300,000 coverage rate since the law was passed. Last year the basic coverage was reduced 17.5% and this year reduced still further from 25% to 31%.

There has been great cooperation between the Insurance Commissioner, Berri Balka, the St. Paul Fire and Marine Insurance Company and the Nebraska Medical Association in implementing this new law.

Even the lawyers are envious of our legislative position and when they invited me to their Annual State Bar luncheon last fall they complimented us on

the good job we had done and stated they were now where we were two years ago and wished they had legislation worked out for their profession.

While at that luncheon, the subject of advertising came up which they are wrestling with and trying to resolve. I would hope that the M.D.s in our Association never have to stoop so low as to solicit patients by the trickery methods available in advertising.

There are a number of other interesting subjects that I could visit with you about, but I've talked longer than I should so will wind this up.

Time does not permit me to thank each and every member that has made this last year possible for me.

I look forward to the new generation in our Association with its new Articles and By-Laws and the effort to get new and young men into our society.

I would be remiss if I didn't express my appreciation to the entire, diligent, faithful and devoted staff for the help and support they have given me.

Finally, my thanks to having this great opportunity of being your President. With the oncoming leadership, I can see only bigger and better things for our Association and with your support they can not fail. Thank you.

The Speaker called for approval of the minutes of the Fall Session meeting of the House of Delegates, and these were approved as printed in the December, 1977, issue of the Nebraska Medical Journal.

Following selection and approval of Reference Committee members, the following Nominating Committee was selected and approved:

- 1st District - Dr. Robert Stryker, Omaha
- 2nd District - Dr. Vernon Garwood, Lincoln
- 3rd District - Dr. David McMaster, Auburn
- 4th District - Dr. Dwaine Peetz, Neligh
- 5th District - Dr. Warren Miller, Columbus
- 6th District - Dr. John Hansen, Wahoo
- 7th District - Dr. R. L. Cassel, Fairbury
- 8th District - Dr. Robert Rasmussen, Chadron
- 9th District - Dr. Stanley Nabity, Grand Island
- 10th District - Dr. Earl Dean, Hastings
- 11th District - Dr. Bruce Claussen, North Platte
- 12th District - Dr. Allan Landers, Scottsbluff

The following Reference Committee assignments were made:

Reference Committee #1

- Annual Audit
- Board of Directors
- Medical Service
- Ad-Hoc Committee on Cost Containment
- Ad-Hoc Committee on Federal Legislation (Re: Cost Containment)
- Resolution #7 — Outline of Factors Responsible for Increasing Cost of Medical Care
- Resolution #10 — Hospital Sale of Cigarettes

Reference Committee #2

- Delegate to AMA — Clinical Session
- Delegate to AMA — Special Regional Meeting
- Life Membership Requests
- Policy
- Resolution #9 — Health Education of Patients

Reference Committee #3

- State Department of Health
- Health Planning
- Maternal and Child Health
- Constitution and By-Laws
- Ad-Hoc Committee on Federal Legislation (Re: Health Planning)
- Resolution #4 — Portable Scanner Equipment

Reference Committee #4

Medical Education
Medicine and Religion
Mental Health and Mental Retardation
Public Relations
Ad-Hoc Liaison Committee with State Governmental Agencies
Resolution #3 — Admitting Procedure of University Medical School
Resolution #6 — Health Education of the Public
Resolution #8 — Coordination of Health Education of the Public

Reference Committee #5

Nebraska Medical Foundation, Inc.
Creighton University School of Medicine
University of Nebraska College of Medicine
Medicolegal Advice
Resolution #1 — Medical Ethics
Resolution #5 — Equal Third Party Payment

Reference Committee #6

Emergency Medical Service
Ad-Hoc Committee on Federal Legislation (Except portions re: Cost Containment and Health Planning)
Resolution #2 — Commission on the Cost of Medical Care
Resolution #11 — Federal Regulations and Cost Controls

The Speaker read a suggested protocol for implementation of the proposed Articles and By-Laws, and this was approved by the House.

The House recognized Dr. H. C. Stewart for having served six years on the Board of Councilors.

There being no further business, the House was recessed until Monday morning.

SECOND SESSION

The second session of the House of Delegates was held Monday, May 1, 1978.

The meeting was called to order by the Vice Speaker, Dr. Landgraf. Roll call showed 66 delegates present and the meeting was declared in session.

The Vice Speaker called for approval of the minutes of the first session of the House of Delegates and these were approved.

The Chair called for reports from Reference Committees and the following were presented:

Reference Committee #3

Reference Committee #3 considered all or parts of five reports and one resolution. Your Reference Committee submits the following report and recommendations:

(1) REPORT OF THE STATE DEPARTMENT OF HEALTH

This report is largely informational in nature and is appreciated as such. Since Dr. Smith was not present to speak to his report, an unresolved concern remains. The report refers to the Department of Health launching "a major diabetes project" and with this in mind, a question is raised as to whether the NMA was consulted about this project and a further question was raised as to the funding of the project.

Recommendation:

Your Reference Committee recommends acceptance of the report and further recommends these questions be forwarded to Dr. Smith together with the request that the President of the Nebraska Medical Association be informed as to the answers to these questions.

MR. SPEAKER, I MOVE THE ADOPTION OF

THIS SECTION OF OUR REPORT. This was approved by the House.

(2) REPORT OF THE HEALTH PLANNING COMMITTEE

This report is informational in nature and calls for no specific action. Your Reference Committee commends the Health Planning Committee for keeping abreast of the tremendous volume of material being sent to them from a multitude of sources.

Recommendation:

It is the recommendation of your Reference Committee that increased monitoring of the Health Systems Agencies in Nebraska be undertaken and that an ad-hoc committee be appointed to accomplish the dual purposes of monitoring HSA meetings and activities and providing the NMA Headquarters Office with information suitable for dissemination to the Association membership concerning HSA activities, meeting times, places, etc.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(3) REPORT OF THE MATERNAL AND CHILD HEALTH COMMITTEE

The report of this committee includes a resolution calling for the study of infant deaths in Nebraska and further includes a proposed perinatal mortality questionnaire. This questionnaire resembles a successfully used questionnaire concerning maternal deaths in Nebraska.

Recommendation:

It is the recommendation of this Reference Committee that the Maternal and Child Health Committee continue to pursue this subject and to define and develop such forms as are appropriate to this end.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(4) REPORT OF THE AD-HOC COMMITTEE ON FEDERAL LEGISLATION (RE: HEALTH PLANNING)

This portion of this report deals with several proposals for amendments to the Health Planning Act. The ad-hoc committee report indicates strong support of the AMA's comments dealing with proposals for changing the Health Planning Act.

Recommendation:

Your Reference Committee recommends acceptance of this portion of the report as written and commends the committee for continuing to monitor federal health legislation.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(5) RESOLUTION #4 — HOLT & NORTHWEST MEDICAL SOCIETY — PORTABLE SCANNER EQUIPMENT

This resolution read as follows:

WHEREAS, the quality of rural medicine could be greatly improved by the use of portable scanner equipment;

THEREFORE, BE IT RESOLVED rural areas should be allowed to obtain portable equipment and consultation from wherever possible.

In view of the absence of the author of this resolution, there are numerous uncertainties as to its

intended meaning. Your Reference Committee together with those testifying has rewritten the resolution with what it believes to be the intended content. The substitute resolution to read as follows:

WHEREAS, the quality of rural medicine could be greatly improved by the use of mobile nuclear scanner equipment;

THEREFORE, BE IT RESOLVED that the state regulatory body concerning nuclear medicine be made aware of this problem and appropriate changes be made in regulations to allow for this service.

Recommendation:

It is our recommendation that this substitute resolution be forwarded to the Policy Committee (Board of Directors under the provisions of the new Articles and By-Laws) for further study and forwarding with comments to the appropriate State of Nebraska officials.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(6) REPORT OF THE CONSTITUTION AND BY-LAWS COMMITTEE

Your Reference Committee recommends amendment to the proposed Constitution and By-Laws as follows:

Page 40, second paragraph: "Qualifications. Members of the Council on Professional Ethics shall be chosen from the members of the Nebraska Medical Association who have demonstrated . . ."

Page 44, third paragraph: "The Scientific Sessions Committee shall also be responsible for sponsoring or co-sponsoring continuing medical education programs."

Page 47, first line: ". . . regarding postgraduate education for the physicians of the state, and shall be responsible for approving and providing accreditation to organizations and institutions for CME programs."

Your Reference Committee recognizes several other areas of the proposed Articles and By-Laws that are or may be of some future concern, but believes this as it now reads to be an acceptable functioning, proper, workable document. We further believe that the areas of expressed concern in the Reference Committee meeting dealing with the overlapping of a component society into two Councilor Districts, and confusion about possible dual memberships between house staff component societies and component county societies to be items for further consideration and development by the Constitution and By-Laws Committee.

Recommendation:

With these proposed amendments, your Reference Committee recommends acceptance of the new Articles and By-Laws.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded. Dr. Francis moved that Chapter VI, Section 1, of the proposed By-Laws concerning delegate apportionment, be amended by substituting the existing Section of the current By-Laws. This was seconded and following discussion, Dr. Dunlap said the Reference Committee did not approve this amendment and has not had time to study this, and as Chairman of this Committee, he did not approve of this amendment. The motion was made and seconded to table the motion to amend, and this was approved.

Dr. Francis moved that under the provisions in the Articles concerning referendum, this question be sub-

mitted to the membership for their vote. After a brief delay, the motion was seconded and there was further discussion. Dr. Prince moved to postpone the motion indefinitely. This was seconded and passed.

Dr. Sadaj moved that Chapter VI, Section 7, concerning House Officer delegates, be amended by deleting the last portion reading, "Provided further that if the membership of either House Staff Association exceeds 50 members, then such Association shall be entitled to one additional delegate for each 50 members or major fraction (50%) thereof." and additional delegates would be on the same basis as regular delegates. This would mean there would be a minimum of two delegates from each school and additional delegates in accordance with the schedule used for regular delegates. Following discussion, this motion lost.

This section of the Reference Committee report was approved by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #3 AS A WHOLE. This was approved by the House.

Respectfully submitted,
Dr. James H. Dunlap, Norfolk,
Chairman
Dr. Charles H. Bressman, Omaha
Dr. Gordon D. Francis, Grand Island

Reference Committee #1

Reference Committee #1 considered five reports and two resolutions. The Reference Committee submits the following report and recommendations.

(1) ANNUAL AUDIT

Recommendation:

Your Reference Committee recommends adoption of the Annual Audit.

MR. SPEAKER, I MOVE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(2) REPORT OF THE BOARD OF DIRECTORS

Recommendation:

Your Reference Committee recommends adoption of the report of the Board of Directors.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(3) REPORT OF THE MEDICAL SERVICE COMMITTEE

Recommendation:

Your Reference Committee recommends adoption of the report of the Medical Service Committee and commends Dr. Roffman and the entire Medical Service Committee for their excellent work in monitoring all legislative bills that came up during this legislative session.

MR. SPEAKER, I MOVE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(4) REPORT OF THE AD-HOC COMMITTEE ON COST CONTAINMENT

Recommendations:

1) Your Reference Committee recommends approval of the report of the Ad-Hoc Committee on Cost Containment.

2) Your Reference Committee recommends that this committee be commended for their excellent work.

3) Your Reference Committee recommends that this committee should remain in existence to implement their recommendations.

MR. SPEAKER, I MOVE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(5) RESOLUTION #7 — GREATER OMAHA MEDICAL SOCIETY — OUTLINE OF FACTORS RESPONSIBLE FOR INCREASING COST OF MEDICAL CARE
AD-HOC COMMITTEE ON FEDERAL LEGISLATION (RE: COST CONTAINMENT)

Resolution #7 and that portion of the report of the Ad-Hoc Committee on Federal Legislation concerning cost containment were considered together. The resolution reads as follows:

WHEREAS, each citizen should be concerned with the economic impact of medical care on himself, his family, and his country, and

WHEREAS, there has been considerable numbers of articles, editorials, and news releases appearing in the lay press suggesting that physicians are responsible for a significant part of rising medical care costs which are "escalating" at a rate beyond the country's general rate of inflation, and

WHEREAS, there have been a number of voluntary, legislative and regulatory proposals purported to curtail, limit, and/or reduce these costs by changing the professional, personal, social, or economic relationship between the patient and his physician;

THEREFORE BE IT RESOLVED, that the American Medical Association develop a detailed working outline of the factors contributing to the cost and the increasing cost of medical care; that the outline be periodically reviewed and updated; and that such outline be distributed widely to members, medical and hospital associations, members of the press, and legislators so that proposals to modify medical care reimbursement may be reviewed for their impact on the totality of these factors as well as for their impact on the quality and accessibility of medical care.

Recommendation:

Your Reference Committee recommends approval of Resolution #7.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(6) RESOLUTION #10 — GREATER OMAHA MEDICAL SOCIETY — HOSPITAL SALE OF CIGARETTES

This resolution reads as follows:

WHEREAS, cigarette smoking cannot be shown to be harmless to anyone, and

WHEREAS, cigarette smoking is harmful to the health of many of its practitioners, and

WHEREAS, the sale of cigarettes by hospitals is an implicit disclaimer of their health hazard to the public, and

WHEREAS, the sale of cigarettes by hospitals is an implicit promotion of cigarettes to the public, and

WHEREAS, the medical profession has a long tradition of not endorsing products that are potentially harmful when they provide no concomitant benefit; be it

RESOLVED, that the physicians of the Nebraska Medical Association endorse and support efforts being made to discontinue the sale of cigarettes within hospitals and recommend the Nebraska Medical Association adopt a similar resolution to encourage physicians and medical staffs to work toward the goal of discontinuing cigarette sales in their respective hospitals and health care facilities.

Recommendation:

Your Reference Committee recommends that the RESOLVED be amended by deleting the word, "discontinue" and substituting the words, "recommend against." We recommend adoption of this resolution as amended.

MR. SPEAKER, I MOVE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

MR. SPEAKER, I MOVE ADOPTION OF THE REPORT OF REFERENCE COMMITTEE #1 AS A WHOLE. This was approved by the House.

Respectfully submitted,
Dr. Russell L. Gorthey, Lincoln,
Chairman
Dr. William Rumbolz, Omaha
Dr. Dwaine Peetz, Neligh

Reference Committee #2

Reference Committee #2 considered four reports and one resolution. Your Reference Committee submits the following report and recommendations:

(1) REPORT OF THE DELEGATE TO AMA — 1977 CLINICAL MEETINGS

This report was reviewed by your Reference Committee and the following items were of special interest to the House of Delegates:

1) The revision of the AMA's Principles of Medical Ethics was reviewed, and in our delegates view, has serious flaws especially those which relate to Sections VI and X. These revisions are being considered by Reference Committee #5.

2) The AMA House of Delegates urged that peer review be conducted for both members and non-members of all State Medical Societies.

The committee reviewed the remainder of the report for informational purposes and found no other items requiring the action of this House.

Recommendation:

With these comments, we recommend adoption of the report of the Delegate to the AMA — 1977 Clinical Meeting.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(2) REPORT OF DELEGATE TO AMA — SPECIAL REGIONAL MEETINGS, DALLAS, TEXAS

This report was reviewed, and it was indicated that this was an effort to establish better communications between the AMA leadership and the AMA membership. Testimony brought out that the AMA has thus far inadequately explained to the public and to the media the many factors responsible for rising medical costs.

Recommendation:

We recommend adoption of the report of the Delegate to the AMA — Special Regional Meeting, Dallas, Texas.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(3) LIFE MEMBERSHIP REQUESTS

Your Reference Committee considered the following requests:

Cheyenne-Kimball-Deuel:

Dr. C. B. Dorwart, Sidney

Dawson County:

Dr. O. P. Rosenau, Cozad

Gage County:

Dr. Clarence R. Brott, Beatrice

Greater Omaha Medical:

Dr. Arthur W. Abts, Omaha

Dr. Michael Crofoot, Omaha

Dr. Werner P. Jensen, Omaha

Dr. Wilbur A. Muehlig, Omaha

Dr. Floyd C. Nelson, Omaha

Dr. John R. Schenken, Omaha

Dr. Robert S. Wigton, Sr., Omaha

Lancaster County:

Dr. William J. Jarvis, Lincoln

Dr. Maynard A. Wood, Lincoln

Platte-Loup Valley County:

Dr. E. G. Brillhart, Morro Bay, Calif.

Scotts Bluff County:

Dr. William J. Gentry, Gering

Dr. H. A. Blackstone, Bridgeport

Recommendations:

1) Your committee reviewed the requests for life memberships and added the name of Dr. C. S. Moran of Omaha on the recommendation of the Greater Omaha Medical Society, and recommends adoption of this request.

2) Your Reference Committee recommends that County Medical Societies adopt the same principles and dues requirements for life membership as those in use and published in the By-Laws of the Nebraska Medical Association.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(4) REPORT OF THE POLICY COMMITTEE

Your Reference Committee reviewed the report of the Policy Committee which was largely informational.

Recommendation:

Item #14, recommended endorsement of a multi-state Western Physician Purchasing Association. After extensive discussion, your Reference Committee recommends endorsement of participation in this Association pending review of the legal ramifications by the Association's attorneys and subsequent referral to and acceptance by the Board of Directors for implementation.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded. There was discussion as to whether or not the NMA should enter into this type of program. It was thought this should be approached cautiously and that it should be studied by the NMA legal counsel before endorsement. It was moved by Dr. Shaffer that this be tabled until the Fall Session so the committee could review this and seek legal counsel and bring it back for discussion at the Fall Session of the House. This was approved, and this section of the Reference Committee report was adopted as amended.

(5) RESOLUTION #9 — GREATER OMAHA MEDICAL

SOCIETY — HEALTH EDUCATION OF PATIENTS

This resolution reads as follows:

WHEREAS, improved education of patients as to the importance of following their physician's instructions has materially reduced morbidity, the need for re-admission to a hospital and mortality; therefore be it

RESOLVED, that the Nebraska Medical Association analyze its present effort in the area of patient education and implement improved techniques for doctors to use in instructing patients relative to their own responsibility in carrying out medical care prescriptions.

Discussion and testimony brought out the recognized need for greater patient education, in essence more explicit informed consent, regarding drugs and treatment.

Recommendation:

Your committee recommends that the Commission on Medical Education and the Commission on Public Affairs review, coordinate and implement this program through NMA communications directly to the membership. Voluminous reference materials relative to this problem presented to the Reference Committee should be made available to both these Commissions.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #2 AS A WHOLE AS AMENDED. This was approved by the House.

Respectfully submitted,

Dr. Stanley Truhlsen, Omaha,
Chairman

Dr. Russell McIntire, Hastings
Dr. Donald Prince, Minden

Reference Committee #4

Reference Committee #4 considered five reports and three resolutions. Your Reference Committee submits the following report and recommendations;

(1) REPORT OF THE MEDICAL EDUCATION COMMITTEE

There was a great deal of discussion concerning the requirements for CME. It was the consensus of the committee that there should be no requirements for continuing medical education for membership in the Nebraska Medical Association.

Recommendation:

It is the recommendation of the committee that all members of the Nebraska Medical Association be encouraged to participate in the AMA Physician Recognition Award Program. It is further recommended that the appropriate commission or committee as appointed by the President, continue to work with the State Board of Examiners concerning relicensure requirements in the State of Nebraska.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

Further discussion evolved around the competency of physicians. It is recognized that the competency of a physician is best determined at the local level. Many hospital medical staffs at the present time reappoint

their staffs as an annual procedure and stipulate at that time as to each physician's competence both physical and mental.

Recommendation:

It is the recommendation of this committee that this procedure be adopted by all medical staffs in the State of Nebraska who are not presently following this procedure. We would recommend that this procedure be implemented and monitored by the appropriate commission of the Nebraska Medical Association.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(2) REPORT OF THE MEDICINE AND RELIGION COMMITTEE

This report was accepted as presented.

Recommendation:

Your reference Committee recommends adoption of the report of the Medicine and Religion Committee.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(3) REPORT OF THE MENTAL HEALTH AND MENTAL RETARDATION COMMITTEE

There was a good deal of discussion concerning the documents created by the Department of Institutions. The rules and regulations implementing this document concerning medication and their use seem to have a direct affect on medical practice.

Recommendation:

The recommendation of the Reference Committee is that since there is a good deal of concern and serious reservation concerning certain portions of these various rules and recommendations, we recommend that the appropriate commission continue to monitor this infringement on medical practice.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(4) REPORT OF THE PUBLIC RELATIONS COMMITTEE

This Reference Committee accepted this report as written, but notes that this committee and the Health Education in Schools and Colleges Committee be appraised of Resolution #8, concerning medical education of the public.

Recommendation:

Your Reference Committee recommends adoption of the report of the Public Relations Committee.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(5) REPORT OF THE AD-HOC LIAISON COMMITTEE WITH STATE GOVERNMENTAL AGENCIES

This report was discussed at length and then accepted.

Recommendation:

Your Reference Committee recognizes the value of the liaison committee and recommends that the function of this committee be continued by the appropriate commission under the new Articles and By-Laws.

MR. SPEAKER, I MOVE THE ADOPTION OF

THIS SECTION OF OUR REPORT. This was approved by the House.

(6) RESOLUTION #6 — GREATER OMAHA MEDICAL SOCIETY — HEALTH EDUCATION OF THE PUBLIC

This resolution read as follows:

WHEREAS, the American Medical Association is engaged in a nation-wide effort to improve the health education of the public, and

WHEREAS, this effort will bear fruit in the long haul of increased life expectancy and improved health, and the possible reduction of cost of medical care; therefore be it

RESOLVED, that the American Medical Association attempt to coordinate its efforts with all other legitimate agencies engaged in the health education of the public including state medical associations, and

BE IT FURTHER RESOLVED, that the Nebraska Medical Association submit this resolution to the American Medical Association at its annual meeting in St. Louis.

There was a great deal of discussion concerning this resolution, and the resolution subsequently was changed and the first RESOLVED has been rewritten by the committee. Following is the recommended resolution developed by the committee;

WHEREAS, the American Medical Association is engaged in a nationwide effort to improve health education of the public, and

WHEREAS, this effort hopefully will bear fruit in the long haul of increased life expectancy and improved health, and the possible reduction of cost of medical care; therefore be it

RESOLVED, that the American Medical Association attempt to coordinate its efforts with State Medical Associations and medical specialty societies primarily as well as with all other legitimate agencies such as health insurance industry, voluntary health organizations, the National Center for Health Education and appropriate federal health education agencies; and be it further

RESOLVED, that the Nebraska Medical Association submit this resolution to the AMA at its Annual Meeting in St. Louis.

Recommendation:

Your Reference Committee recommends the adoption of Resolution #6 as modified.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(7) RESOLUTION #8 — GREATER OMAHA MEDICAL SOCIETY — COORDINATION OF HEALTH EDUCATION OF THE PUBLIC

This resolution read as follows:

WHEREAS, the education of the public in matters relating to the improvement of their health and the avoidance of illness is essential to the long range improvement of the public health, and

WHEREAS, the responsibility of this education falls on the shoulders of all who are involved in the education of our citizens, and

WHEREAS, the long range benefits of improved health not only will increase the life expectancy and the physical and mental quality of life, and may reduce the cost of medical care; therefore be it

RESOLVED, that the Nebraska Medical Association re-assess and augment its present activities in the area of health education of the public; and be it further

RESOLVED, that the Nebraska Medical Association improve its existing efforts in coordinating its health education activities with other legitimate agencies; and be it further

RESOLVED, that the Nebraska Medical Association request the American Medical Association to coordinate its efforts in health education with other legitimate agencies such as the Health Insurance industry, the voluntary health organizations, and the state medical associations.

There was a great deal of discussion concerning the relationship of this **RESOLVED** to that of Resolution #6, and the various differences were pointed out by members who participated in the committee. After much discussion, the resolution was rewritten.

Recommendation:

Your Reference Committee strongly endorsed this amended resolution and recommends its approval by the Nebraska Medical Association:

WHEREAS, education of the public in matters relating to the improvement of their health and the avoidance of illness is essential to the long range improvement of public health, and

WHEREAS, the responsibility of this education falls on the shoulders of all who are involved in the education of our citizens, and

WHEREAS, the long range benefits of improved health not only will increase the life expectancy and the physical and mental quality of life, and may reduce the cost of medical care; therefore be it

RESOLVED, that the report of the Health Education in Schools and Colleges Committee approved by this House at its Fall Meeting in September, 1977, be referred to the Commission on Medical Education for the development of a plan of action to implement the recommendations of this report and that such plan be presented to the House of Delegates for action at its Fall Session, in September, 1978.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(8) RESOLUTION #3 — HOLT & NORTHWEST MEDICAL SOCIETY — ADMITTING PROCEDURE OF THE UNIVERSITY MEDICAL SCHOOL

This resolution read as follows:

WHEREAS, a decidedly absence of rural practitioners exists when prospective medical students are interviewed;

THEREFORE, BE IT RESOLVED rural physicians be included in the admitting procedure of the University Medical School.

There was some disagreement from the members who testified as to whether the intent of this motion was presently being carried out. One member felt there were members of the rural practitioners represented on the Admissions Committee and another delegate felt that they were not represented. The Reference Committee then took the prerogative of rewriting the resolution as follows:

WHEREAS, the admission of students to medical

schools is of importance in practice locations and goals; be it

RESOLVED, that rural physicians be included in the admitting procedure of the University of Nebraska Medical Center, that the NMA Commission on Association Affairs working in conjunction with the University of Nebraska Medical Center to either continue this plan if it is in effect or see to it that it is implemented in this next selection year and henceforth.

Recommendation:

Your Reference Committee recommends adoption of the amended Resolution #3.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #4 AS A WHOLE. This was approved by the House.

Respectfully submitted,
Dr. Michael J. Haller, Omaha,
Chairman
Dr. R. L. Cassel, Fairbury
Dr. Kenton L. Shaffer, Kearney

Reference Committee #5

Reference Committee #5 considered four reports and two resolutions. Your Reference Committee submits the following report and recommendations:

(1) REPORT OF THE NEBRASKA MEDICAL FOUNDATION, INC.

We first considered the report of the Nebraska Medical Foundation, Inc. Discussion in this respect centered around the question of delinquent loans, and we were disappointed that the report did not include any comment on the status of overdue loans.

Recommendation:

With these comments, we recommend adoption of the report of the Nebraska Medical Foundation, Inc.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(2) REPORT OF THE CREIGHTON UNIVERSITY SCHOOL OF MEDICINE

The second item considered was the report of the Creighton University School of Medicine. Members of the audience, as well as members of the committee, wish to express appreciation to the Creighton University School of Medicine for their ongoing, excellent job in the field of medical education.

Recommendation:

Your Reference Committee recommends the adoption of the report of the Creighton University School of Medicine.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(3) REPORT OF THE UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE

Your Reference Committee next considered the report of the University of Nebraska College of Medicine. Comments with respect to this report expressed disappointment that the request for faculty salaries, as submitted by the Board of Regents of the

University of Nebraska, was not approved by the Legislature and the Governor.

Recommendation:

Your Reference Committee recommends the adoption of the report of the University of Nebraska College of Medicine.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(4) REPORT OF THE MEDICOLEGAL ADVICE COMMITTEE

We next considered the report of the Medicolegal Advice Committee. We express our appreciation to the authors of this report for calling the attention of Nebraska physicians to the potential hazards of changing carriers in claims-made type policies. From this discussion, a recommendation came forth: The Insurance and Prepayment Medical Care Committee prepare directions on what a physician must do to secure full-tail coverage when changing from one carrier to another.

We also suggest that the NMA Headquarters Office again prepare a letter calling the attention of the individual physician to the necessity of making sure he has tail coverage when changing carriers and that he have this assurance in writing.

Recommendation:

With these comments, we recommend the adoption of the report of the Medicolegal Advice Committee.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(5) RESOLUTION #1 — GREATER OMAHA MEDICAL SOCIETY — MEDICAL ETHICS

This resolution read as follows:

RESOLVED, that the proposed changes of the Principles of Medical Ethics be placed before the Nebraska Medical Association House of Delegates for discussion and comment.

Your Reference Committee considered this resolution regarding medical ethics. Following considerable interesting and enlightening discussion, the committee agreed that the current Code of Ethics be retained with the additional suggestion that the "Preamble" be modified to read: "These principles are intended to aid physicians individually in maintaining a high level of ethical conduct . . ." This deletes the words "and collectively."

Recommendation:

Your Reference Committee recommends the adoption of Resolution #1.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(6) RESOLUTION #5 — HOLT & NORTHWEST MEDICAL SOCIETY — EQUAL THIRD PARTY PAYMENT

The last issue considered by your Reference Committee was Resolution #5, which read as follows:

WHEREAS, there is an existing discrepancy producing discrimination between urban and rural third party payment;

THEREFORE, BE IT RESOLVED, there be equal third party payment throughout Nebraska without regard to location.

Following considerable discussion which centered around the problem of the Nebraska Medical Association getting involved in controlling fees, it was suggested the RESOLVED portion be changed to read as follows:

THEREFORE, BE IT RESOLVED, that there not be discrimination by third-party payors based on geographic location of the physician.

Recommendation:

Your Reference Committee recommends the adoption of Resolution #5 as amended.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #5 AS A WHOLE. This was approved by the House.

Respectfully submitted,
Dr. C. N. Sorensen, Scottsbluff,
Chairman
Dr. William A. Doering, Franklin
Dr. Howard A. Dinsdale, Lincoln

Reference Committee #6

Reference Committee #6 considered two reports and two resolutions. Your Reference Committee submits the following report and recommendations:

(1) REPORT OF THE EMERGENCY MEDICAL SERVICE COMMITTEE

The report emphasizes and discussion during the related hearing supported the committee's recommendations regarding:

1) The teaching of the public and the recruitment of the public's participation in programs concerning cardiopulmonary resuscitation.

2) The development of better rapid transport systems for critically ill patients especially in rural areas.

3) The establishment of a line of communication among the State Health Department, the various emergency medical systems councils and the Nebraska Medical Association.

4) The expansion of emergency medical care communications systems.

5) The notification of hospitals and their related medical staffs of an emergency room categorization and classification system.

MR. SPEAKER, I MOVE THE ADOPTION OF THE EMERGENCY MEDICAL SERVICE COMMITTEE'S REPORT AND RECOMMENDATIONS AND THIS SECTION OF YOUR REFERENCE COMMITTEE'S REPORT. This was approved by the House.

(2) REPORT OF THE AD-HOC COMMITTEE ON FEDERAL LEGISLATION (RE: NATIONAL HEALTH INSURANCE AND HMO's)

The report requests:

1) Reaffirmation of the Nebraska Medical Association's position on National Health Insurance (NHI) and Professional Standards Review Organization (PSRO).

2) Support of the AMA policy regarding study of a pluralistic approach to evaluation of systems of medical care and that the viability of such systems, as the HMO concept, be proven without government subsidy.

The discussion pertaining to this portion of the Ad-Hoc Committee on Federal Legislation was all supportive.

Recommendation:

Your Reference Committee recommends acceptance of the committee's report and actions.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(3) RESOLUTION #11 — GREATER OMAHA MEDICAL SOCIETY — FEDERAL REGULATIONS AND COST CONTROLS

This resolution read as follows:

WHEREAS, governmental regulations represent a large factor in the increasing cost of medical care in this county, and

WHEREAS, these regulations may or may not improve health care; therefore

BE IT RESOLVED, that the AMA request the Federal Government to refrain from implementing further regulations unless these have been **proved** to decrease health care costs.

The discussion pertaining to the resolution was supportive, but with the following modifications:

In the first and second WHEREAS and the RESOLVED, add the words, "and health care systems" after the word, "regulations." In the RESOLVED, after the words, "health care costs" add the words, "while improving health care." The resolution therefore will read as follows:

WHEREAS, government regulations and health care systems represent a large factor in the increasing cost of medical care in this country, and

WHEREAS, these regulations and health care systems may or may not improve health care; therefore be it

RESOLVED, that the AMA request the federal government to refrain from implementing further regulations and health care systems unless these have been **proven** to decrease health care costs while improving health care.

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS ADOPTION OF RESOLUTION #11 AS MODIFIED. This was approved by the House.

(4) RESOLUTION #2 — GREATER OMAHA MEDICAL SOCIETY — COMMISSION ON THE COST OF MEDICAL CARE

This resolution read as follows:

RESOLVED, that the summary of the National Commission On The Cost Of Medical Care be placed before the Nebraska Medical Association House of Delegates for discussion and comment.

There was extended discussion on this resolution particularly on the AMA Summary of the Report of the National Commission on the Cost of Medical Care.

Recommendations:

1) Dissolution of Resolution #2.

2) The adoption of the following guidelines for the NMA delegates to be utilized during the forthcoming AMA House of Delegates meeting concerning the Report of the National Commission on the cost of Medical Care:

a. Endorse the concern regarding and support the effort of the AMA to study the problems involved in the cost of medical care.

b. Recognize the desirability and need for input

from diverse sources of opinion as to the factors underlying the rising costs of medical care.

c. Express grave concern regarding the release to the public of an AMA sponsored study on cost of medical care before the members of the Association and their delegates have had the opportunity to study the complete report in depth and comment appropriately.

d. Recognize the summary of the Commission's Report, as provided by the AMA, contains no alternative opinion.

e. Recognize there are features of the Commission's Report which are both pro and con existing AMA attitudes and concepts regarding costs of medical care, but until substantive information and data can be provided, Nebraska Medical Association action concerning the specific recommendations of the report cannot be intelligently provided.

f. Maintain strong reservations regarding the concept that the federal government can regulate cost effectiveness in relationship to medical care.

g. As a profession, we must apply the scientific conditions governing our delivery of health care to cost effectiveness in that feasibility must be well demonstrated and documented before implementation.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF YOUR REFERENCE COMMITTEE'S REPORT. This was approved by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #6 AS A WHOLE. This was approved by the House.

Respectfully submitted,
Dr. F. F. Paustian, Omaha,
Chairman
Dr. T. J. Lemke, Columbus
Dr. B. F. Wendt, Lincoln

There being no further business, the House was recessed until Wednesday morning.

THIRD SESSION

The third session of the House of Delegates was held on Wednesday, May 3, 1978.

The House was called to order by the Speaker, Dr. McFadden. Roll call showed 55 delegates present, and the House was declared in session.

Dr. Russell S. Gerard, II, President-Elect of the Iowa Medical Society, was introduced to the House of Delegates.

An oral report was presented by Mrs. Guy Matson, Immediate Past President of the Nebraska Medical Association Auxiliary.

The Chair was assumed by the Vice Speaker, and approval of the minutes of the second session was called for and these were approved.

Dr. Retelsdorf asked for clarification of the status of the proposed new Articles and By-Laws. The Chair indicated that the proposed Articles and By-Laws had been accepted with the exception of Chapter VI, which had been tabled at the Monday session. Dr. Retelsdorf moved that the tabled motion of Dr. Francis concerning delegate apportionment be brought from the table and this was approved.

Following discussion, the vote on the amendment was called for and the motion to amend lost.

Dr. Coe moved that the House adopt the wording in Chapter VI of the proposed Articles and By-Laws. This was seconded and following discussion, a hand vote showed 46 in favor of the motion and 11 against. The motion was adopted by the House.

Dr. Ashby, Chairman of the Board of Directors, informed the House that the Board had approved changing the title of Executive Secretary to Executive Director, and that the appropriate changes should be made in the By-Laws. This was approved by the House.

The Chair called for the report of the Nominating Committee, and Dr. Claussen, Chairman, presented the following slate of officers:

President-Elect — Charles W. Landgraf, Jr., M.D., Hastings

Board of Directors — Members-At-Large:

- 1-year term — Allan C. Landers, M.D., Scottsbluff
- 2-year term — Frederick F. Paustian, M.D., Omaha
- 3-year term — Russell L. Gorthey, M.D., Lincoln

Secretary-Treasurer — Orin R. Hayes, M.D., Lincoln

Delegate to the A.M.A. — John D. Coe, M.D., Omaha

Alternate Delegate to the A.M.A. — Blaine Y. Roffman, M.D., Omaha

Councilors:

- 1st District — Carlyle E. Wilson, Jr., M.D., Omaha
- 2nd District — Louis J. Gogela, M.D., Lincoln
- 3rd District — Myron E. Samuelson, M.D., Wymore
- 4th District — James G. Carlson, M.D., Verdigre

Council on Professional Ethics:

- 1-year term — Stanley Truhlsen, M.D., Omaha
- 2-year term — A. L. Smith, Jr., M.D., Lincoln
- 3-year term — Russell McIntire, M.D., Hastings
- 4-year term — Charles F. Ashby, M.D., Geneva
- 5-year term — C. N. Sorensen, M.D., Scottsbluff

Delegate to North Central Medical

Conference — Dwaine J. Peetz, M.D., Neligh

The Chair called for nominations from the floor. Dr. Doering nominated Dr. Jerald Schenken as Alternate Delegate to the A.M.A., however Dr. Schenken asked that his name be withdrawn. The House approved the slate of officers as presented by the Nominating Committee.

Dr. Wilson asked that the House officially recognize and commend Dr. Lempka for his leadership during the past year. This was approved by the House.

Dr. Francis moved that the House of Delegates of the NMA demonstrate its leadership in the Health Gallery Project by asking each Delegate and Alternate Delegate who have not previously pledged, to pledge \$10.00 per month for the next two years and urge the members of the NMA to follow this example in order that the NMA Auxiliary can meet its goal in 1978. This was unanimously approved by the House.

Dr. Bosley asked that consideration be given to Grand Island as a site for future meetings.

There being no further business, the House was adjourned.

Effect of Oxprenolol on Stage-Fright in Musicians — I M. James et al (Royal Free Hosp, London, England) *Lancet* 2:952-954 (Nov 5) 1977.

The effect of 40 mg oxprenolol on stage-fright was assessed in 24 musicians in a double-blind crossover trial. Musical performance judged by two professional assessors improved. Greatest improvement was seen on the first performance and in those most affected by nervousness.

Cataracts Induced by Topical Dexamethasone in Diabetics — M. E. Yablonski et al (B. Becker, Glaucoma Center, Washington Univ School of Medicine, St. Louis, MO 63110) *Arch Ophthalmol* 69:474-476 (Mar) 1978

Eleven diabetic patients were treated with unilateral topical dexamethasone for 14 to 36 months in an attempt to control their retinopathy. Cataracts developed in the treated eye of nine patients, compared with only one cataract in an untreated eye.

Maternal Smoking, Pregnancy Complications, and Perinatal Mortality — M. B. Meyer (Dept of Epidemiology, Johns Hopkins Univ, Baltimore, MD 21205) and J. A. Tonascia, *Am J Obstet Gynecol* 128:494-502 (July) 1977.

Analysis of data from the Ontario Perinatal Mortality Study has shown that perinatal mortality increases directly with the level of maternal smoking during pregnancy. Increases in smoking level are associated with increases in the frequency of early fetal deaths and of neonatal deaths due to premature delivery. These deaths in turn are associated with smoking-related increases in the incidence of bleeding during pregnancy, abruptio placenta, placenta previa, and premature and prolonged rupture of the membranes.

Clinical Observation on Brittle Diabetes — A. Lev-ran (Scripps Clinic and Research Foundation, LaJolla, CA 92037) *Arch Intern Med* 114:372-376 (Mar) 1978.

The brittleness of severe diabetes was calculated as the mean of differences of blood

glucose between two consecutive days at four time points (fasting, one and two hours after breakfast, and two hours after lunch). Mean daily difference (MDD) had a unimodal distribution; patients with a MDD greater than 100 mg/100 ml were classified as most brittle. There was no correlation between MDD and insulin requirement. The brittle diabetics received 26 to 48 units of insulin/day. The insulin-resistant patients had low MDD values. No difference was found between patients with brittle diabetes and stable matched controls in insulin-binding capacity or total insulin. It was found that the stable dosage caused less brittleness than a sliding-scale regimen and that routine injection of 4 units of regular insulin before meals slightly decreased the mean diurnal glycemia level but increased the number of hypoglycemia. In two brittle diabetics, the blood glucose level was stabilized on intravenously administered insulin infusion, and in these patients, meals caused only a moderate hyperglycemia.

Prognostic Factors in the Survival of 1,484 Stroke Cases Observed for 30 to 48 Months — H. A. H. Abu-zeid et al (Univ of Manitoba, Winnipeg, Manitoba, Canada) *Arch Neurol* 35:121-125 (Mar) 1978.

Survival and factors affecting survival were studied in 1,484 new cases of acute definite stroke occurring between Jan 1, 1970, and June 30, 1971, in Manitoba. The 962 infarctions, 279 hemorrhages, and 243 unidentified strokes were ascertained from hospital claim reports. Personal, clinical, and laboratory data were collected from hospital medical records, death certificates, and autopsy reports. Patients were followed up till December 31, 1973, to determine survival. Survival was significantly better in infarction than in hemorrhage, in subarachnoid hemorrhage than in intracerebral hemorrhage, in men than in women, in the young than in the old, in the married than in the single, in hemorrhage cases from rural areas than from urban areas, and in those discharged to home than in those transferred to long-term care hospitals. These data may help in predicting the outcome of stroke and in planning more efficient care.

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"Aren't you the fellow who checked my Form 1040
last year?"

prescribing, please consult complete product information, a copy of which follows:

iveness of Valium (diazepam) in long-term use, that is, more than 1 year, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with chronic angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery). Withdrawal symptoms (similar to those with barbiturates, alcohol) may occur following abrupt discontinuance (convulsions, tremor, muscle cramps, vomiting, sweating). Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of their potential for habituation/dependence.

Use in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of the increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Use in treatment of psychotic patients; should not be employed in the absence of appropriate treatment. When using oral form adjunctively in convulsions, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant therapy; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

Precautions: To reduce the possibility of venous thrombosis, phlebitis, local swelling, and, rarely, vascular impairment when used I.V.: inject slowly at least one minute for each 5 mg (1 ml) given; do not use the dorsum of hand or wrist; use extreme care to avoid intravascular administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to inject Valium directly I.V., it may be injected slowly through the infusion line as close as possible to the vein insertion.

Exercise extreme care in elderly, very ill, or those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concurrent use of barbiturates, alcohol or other CNS depressants increases the risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage by 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of respiration.

Exacerbated tonic status epilepticus in patients treated for petit mal or petit mal variant status.

Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal cramps, vomiting, sweating). Keep addiction-prone individuals under careful surveillance because of predisposition to habituation/dependence. Not recommended for OB use.

Safety not established in neonates (age 30 days or less); profound CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be reversed after 15 to 30 minutes. If no relief after third administration, consider adjunctive therapy is recommended.

Interactions: If combined with other psychotropics or anticonvulsants, consider individual pharmacologic effects—particularly with known CNS depressants which may potentiate action of Valium (diazepam), i.e., sedatives, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective dose in elderly and debilitated to preclude ataxia or oversedation (initially 2 1/2 mg once or twice daily, increasing gradually as needed or as tolerated).

Injectable: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

Injectable: Venous thrombosis/phlebitis at injection site, hypoaesthesia, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

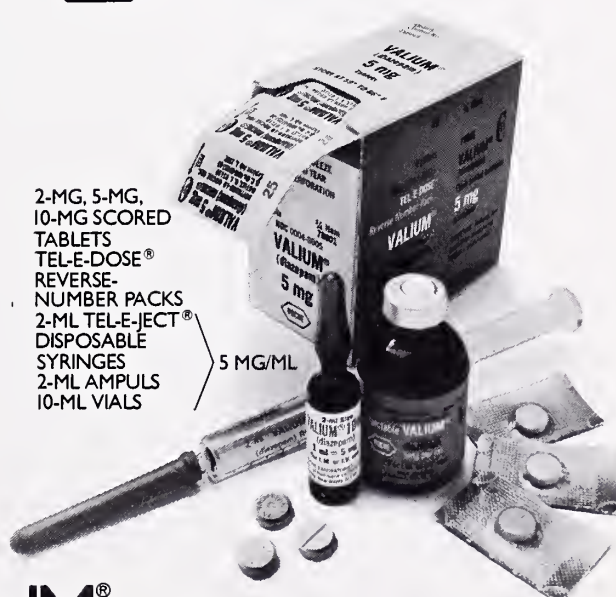
In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levothartanol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

Supplied: Tablets, 2 mg, 5 mg and 10 mg, bottles of 100 and 500; Tel-E-Dose® (unit dose) packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.



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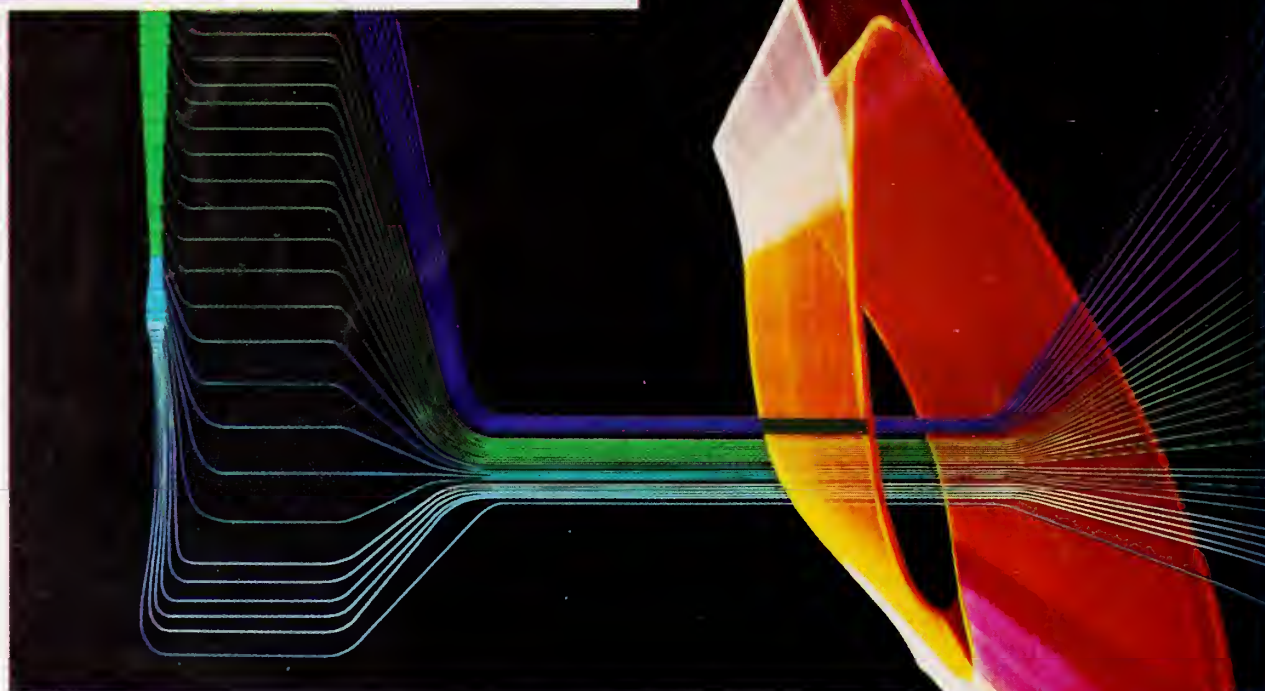
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Improved Survival Times in Multiple Myeloma Treated With Melphalan, Prednisone, Cyclophosphamide, Vincristine and BCNU: M-2 Protocol — D. C. Case, Jr et al (B. J. Lee, III, 1275 York Ave, New York, NY 10021) Am J Med 63:897-903 (Dec) 1977.

Seventy-three patients in whom multiple myeloma could be evaluated were treated with a combination drug protocol (M-2), consisting of melphalan, prednisone, cyclophosphamide, vincristine, and BCNU (1,3-bis (2-chloroethyl 1)-1-nitrosourea). All patients were classified according to the clinical staging system of Salmon and Durie; 75% were in stage III. Total tumor cell number was calculated by the method of Salmon. A significant objective remission was obtained in 40 of 46 (87%) previously untreated patients, whose median duration of response is presently 20+ months. Twenty-seven of these 40 responders are still in remission. Thirteen of 26 (50%) previously treated patients responded. With eight of these still in remission, the median duration of response is 22+ months. The median times between the first dose and an established response were two and three months for the previously untreated and treated groups, respectively. The duration of remission in the more rapid responders does not appear to be shorter. The response rate does not appear to correlate with the type of immunoglobulin or light chain secreted. One patient, without immunoglobulin secretion, has been in remission for 45+ months, and three with primary amyloid have failed to respond.

Postsplenectomy Thrombocytosis — D. H. Gordon et al (J. M. Bennett, 601 Elmwood Ave., Rochester, NY 14642) Arch Surg 113:713-715 (June) 1978.

During the past two years, postoperative thromboses of parts or all of the splanchnic venous circulation developed in four of 30 patients with myeloproliferative disorders who had undergone splenectomy. The patients' courses were marked by platelet abnormalities, both quantitative and qualitative. In an attempt to avoid this complication, aspirin and low-dose heparin sodium were administered and there has been no evidence of thrombosis in these patients.

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The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy. **Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

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INDICATIONS For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS Hypersensitivity to oxycodone, aspirin, phenacetin or caffeine.

WARNINGS **Drug Dependence** Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of PERCODAN®, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, PERCODAN® is subject to the Federal Controlled Substances Act.

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Usage in pregnancy Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, PERCODAN® should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Usage in children PERCODAN® should not be administered to children.

Salicylates should be used with caution in the presence of peptic ulcer or coagulation abnormalities.

PRECAUTIONS **Head injury and increased intracranial pressure** The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions The administration of PERCODAN® or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special risk patients PERCODAN® should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

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ADVERSE REACTIONS The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

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DOSAGE AND ADMINISTRATION Dosage should be adjusted according to the severity of the pain and the response of the patient. The usual adult dose is one tablet every 6 hours as needed for pain.

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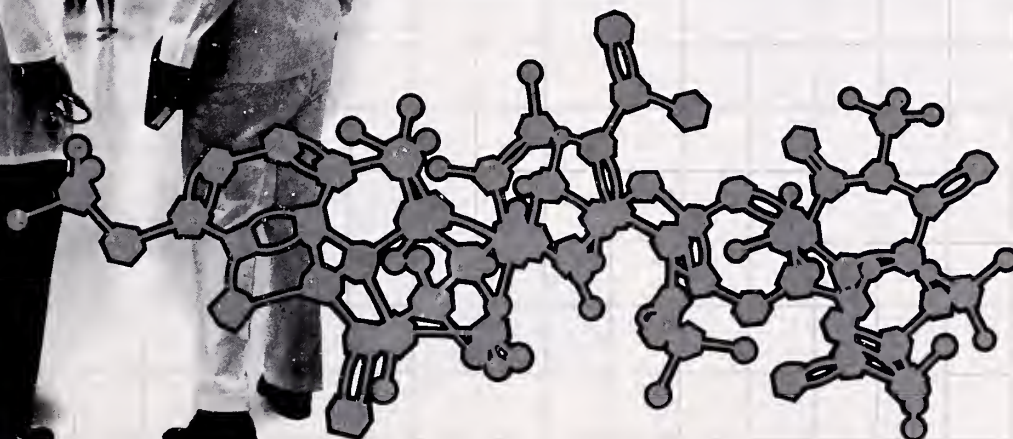
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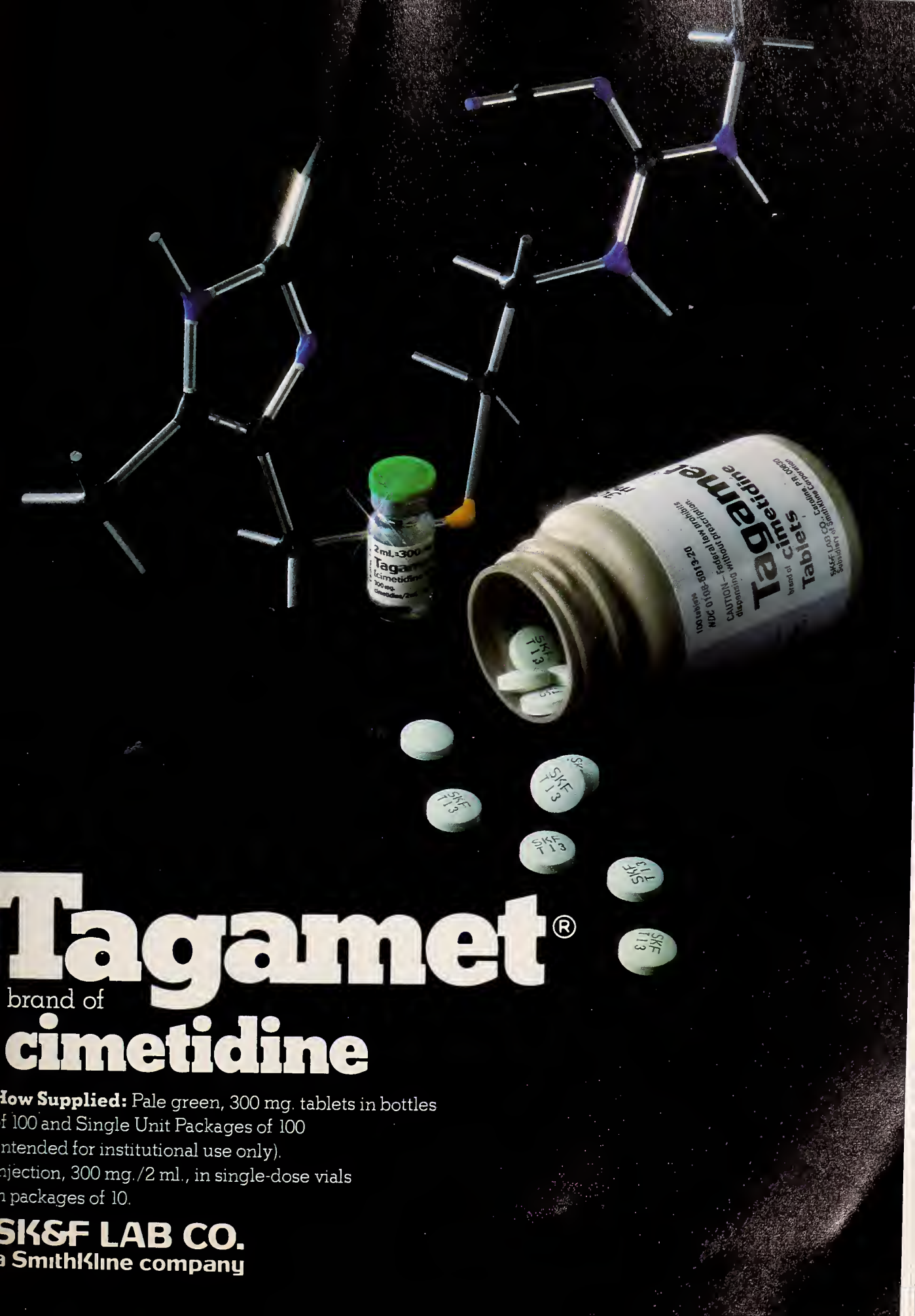
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Neosporin Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

Neomycin

Staphylococcus
Haemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Corynebacterium
Streptococcus
Pneumococcus

Bacitracin

Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B

Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

In vitro overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Neosporin[®] Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units, zinc bacitracin 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base), special white petrolatum qs, in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns covering more than 20 percent of the body surface is

affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measure should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

100 mg

250 mg

500 mg



Tolinase[®] **tolazamide, Upjohn**

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695 6

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Medical Therapy of Angina Pectoris — W. W. Parmley (Univ of California, San Francisco, CA 94143) *Angiology* 28:865-872 (Dec) 1977.

The pathophysiology of angina pectoris is best understood as an imbalance between oxygen supply and demand. The primary determinants of myocardial oxygen demand are heart rate, arterial pressure, heart size, myocardial contractility, and myocardial mass. The medical therapy of angina pectoris is directed toward reducing myocardial oxygen demand by reducing the workload of the heart and the specific determinants listed. The most common medications used in the treatment of angina pectoris are nitroglycerin and propranolol. Nitroglycerin reduces myocardial oxygen demand primarily by reducing heart size and arterial pressure. Propranolol reduces oxygen demand primarily by reducing heart rate. Medical therapy is generally effective in controlling the symptoms of angina pectoris in 80% or more of the patients.

Problems in the Control of Hypertension in the Community — M. Shapiro et al (Dept of Medicine, Univ of California, Los Angeles, CA 90024) *Can Med Assoc J* 118:37-38 (Jan 7) 1978.

A survey was conducted in Montreal to determine the extent, nature, and distribution of the control of hypertension. Of the 12,055 persons screened in shopping centers, workplaces, and a random sample of homes in four census tracts, the hypertension was not controlled in 69.0% to 80.3% of those with the condition in each setting. Nearly two thirds were aware of their condition; 13% were aware but had never been treated; 13% were receiving treatment inadequate to control their hypertension; and 11% had discontinued treatment, mostly on the advice of their physician. Among those screened in their homes, discontinuance of therapy was most often by those with low income, but lack of awareness of their condition was no more prevalent in this group than in the other income groups. Efforts to control hypertension should be directed to the variety of causes for lack of control and for which screening along may be inadequate.

**Brief Summary of Prescribing Information
Combined TEGOPEN® (cloxacillin sodium)
Capsules and Oral Solution**

For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

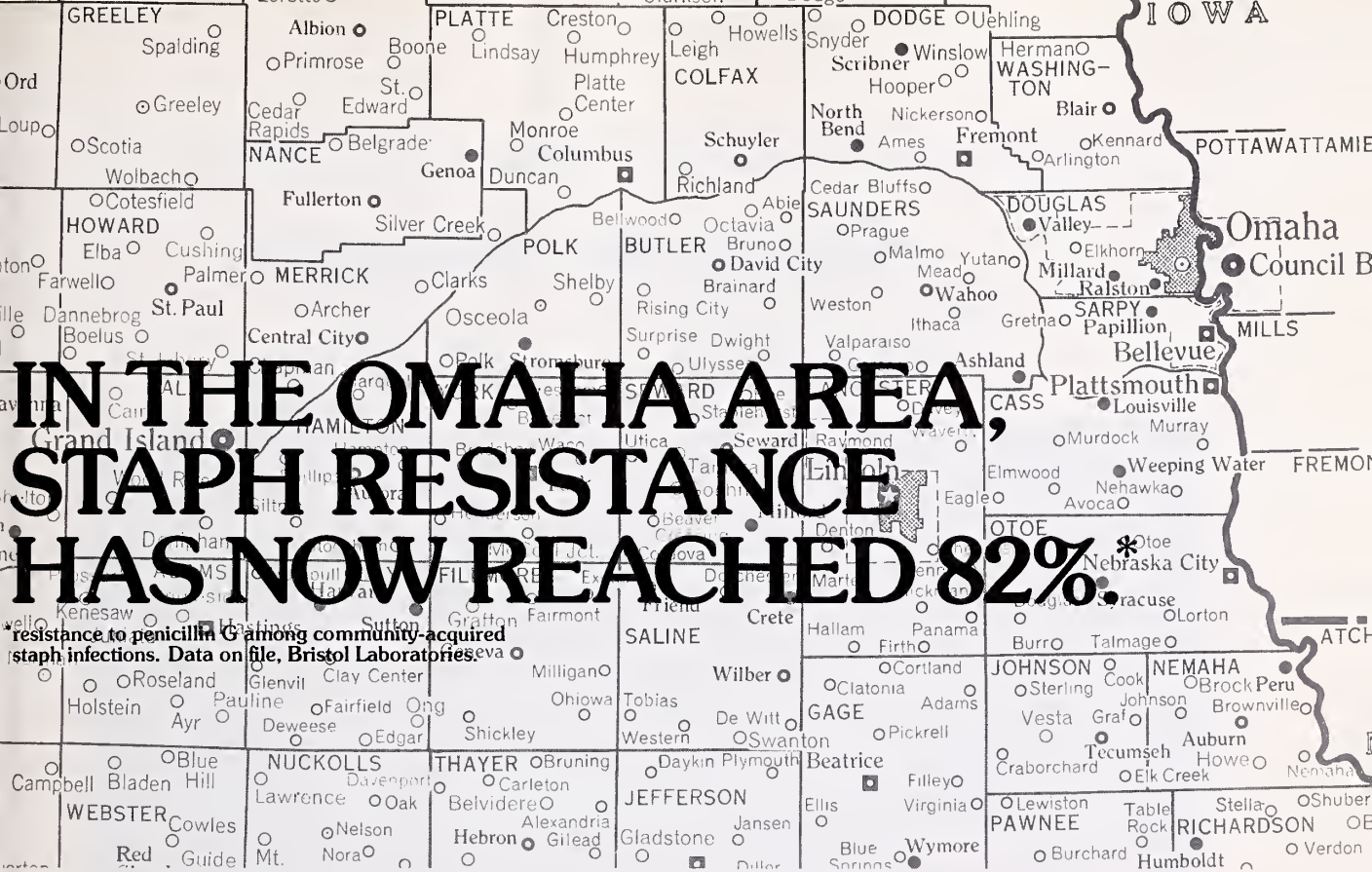
Usual Dosage: Adults: 250 mg. q. 6h.

Children: 50 mg./Kg./day in equally divided doses q. 6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

Supplied: Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100. Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.





WHEN YOU CAN'T RULE OUT STAPH, CONSIDER

TEGOPEN®

(cloxacillin sodium)

„THE PENICILLIN OF TODAY”

- Effective against nonpenicillinase-producing staphylococci, beta-hemolytic streptococci, and pneumococci.†

†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *in vitro* data is unknown.

- 10 times more active against strep than staph.
- Well absorbed from the G.I. tract.‡

‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.



Please see brief summary
for prescribing information.

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650 mg. acetaminophen



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Pre-moistened toilet tissue for gentleness to tender skin

gentle: dry tissue can irritate patients with sensitive skin due to hemorrhoids, pruritus ani, vaginitis and rectal infections/irritations. Moist, cushiony FRESH'N tissue is gentle on tender skin and lets patients cleanse thoroughly with minimal discomfort.

clinically tested and proven safe¹: contains ingredients that can cleanse without further irritation.

clinically tested and proven superior: users of FRESH'N were found to be significantly cleaner than users of the leading dry toilet tissue.

biodegradable: flushable; under ordinary use it should not harm plumbing or septic tanks.

convenient: won't shred like regular tissue that's been held under the faucet, eliminates laundering wet washcloths; wall-mounted dispenser helps retain moisture and keeps FRESH'N within easy reach.

Reference:

1. Based on clinical studies. Data on file, American Can Co.

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OM-9-77



THE NEBRASKA MEDICAL JOURNAL

THE DOCTOR'S BILL

The title of the address at my M.D. graduation was The Doctor's Bill; it was a play on words, and the talk was good. Hamburgers were five cents each then, or six for a quarter. And I just paid two dollars for one. Our fees have gone up, I keep hearing, but in proportion, I believe, to other things. Meanwhile, a once-two-thousand-dollar automobile is now twelve thousand dollars, and a forty dollar suit is now five times as much.

I told the restaurant lady about the five cent hamburger, and she said That's cheap. But consider this. The two hundred and fifty dollar suit is the same as the once-forty-dollar suit. The twelve thousand dollar luxury car is the equivalent of the one-two-thousand dollar one. But what *we* have to sell is not at all the same as it once was, say a quarter of a century ago. For we have brought mortality rates down and we have extended life spans, what with modern anesthesia, blood transfusions, kidney and corneal transplants, antibiotics, tranquilizers, heart valve and hip replacements, and chemotherapy. So if our fees have gone up, as everything else has gone up, what we are giving is not to be compared with the same suit or the same automobile; it is incalculably better.

I could once take a lady out to a fifty-cent dinner; the same dinner now comes to five dollars. But if we charge more for our service, it is an almost infinitely better service. The clothier and the automobile dealer have raised their prices, and they are giving you the same article. We're giving you a much better one. Remember that.

—F.C.

THERE'S NO PLACE LIKE HOME

I was in a hospital, and they worked over me, as we used to say, and I was told I could go home on the eleventh or the twelfth day.

And when one of those days was almost in sight, I remembered Dorothy who said (in the movie, not in the book), There's no place like home. So I asked my doctor if I could go home on the tenth day, and he said sure.

Dorothy clicked her heels and said, There's no place like home, and I clicked my heels, and I said on the ride back, There's no place like home.

I have since spoken to once-operated-on friends, and they have had the same experience; they wanted with all their hearts to go home. Surgery was over, and there was only the endless lying in bed and sitting in chairs, walking the hospital corridors, and watching daytime television and seeing how bad it was, and reading old thumbed-through magazines.

What they thought, while looking at their snail's-pace-moving watches, was, There's no place like home. They wanted, as I did, the feeling of security you meet when you walk into your home, your own bed, your own bathroom, your well-wishers' telephone voices, and your friends who can come and see you, what with visiting hours now round the clock.

Whatever you have designated as H-day, or home-going or discharge day, it might be well to know that the patient is often more anxious than you know to leave the hospital with its machines, its parades of sick people, its dullness, its food, its many inconveniences, and its long hours of mind-wasting. And to know that what with mind-over-disease, think-positive, and belief-in-recovery philosophies, you will probably do better at home than in the hospital, with its many unpleasantnesses. I know you can get, or call for, help in the hospital, but you don't need all that help after a week of waiting for the wound to heal. And it may be good to send the patient home a day or two earlier. Because there's no place like home.

—F.C.

SHOULD THE DOCTOR CALL THE PATIENT?

The doctor said, We'd better get an electrocardiogram to see if your heart is all right; or, I'm going to have my laboratory take an x-ray of your chest to see if there is any tumor. And the patient was told to go home, and he did, and he thought about it. The EKG and the x-ray were dry before he finished dressing, and it would have been nice if the doctor had said, You're all right, the test was negative. It might have been more than a simple courtesy if the physician had told the patient, the x-ray doesn't look quite right to me, I'm going to have a surgeon look at it.

Either way, the patient would have been better off if the doctor had told him what the test showed, before he left the office. If the result was normal, he would have felt better, and if it was not, he would not have had to worry for a week or two before beginning a constructive program designed to get him well.

And there is always the telephone. It would be considerate if the doctor called the patient to tell him what the test showed; I

think the call needed to be made; by the doctor, from the doctor to the patient. We are too busy now, seeing all those patients, having all the forms filled out, and forgetting that patients have feelings, that they are concerned, and that they worry. I think it would be nice if the doctor called the patient; or if he took time off to look at the electrocardiogram or at the x-ray and communicated with the patient before he left the office.

—F.C.

ON KEEPING YOUR SANITY

Definitions of sanity leave me cold. They change every time you look at them, and they make no sense. What is right in one state is wrong in another, what is sane in one time is mad in a second, and what is legal is not medical.

Yes, Virginia, and Nebraska, there is a sanity clause.

—F.C.

"Another Look" Operation for Colon Carcinoma

COLORECTAL cancer accounts for 12-15% of all cancer deaths.¹ Obviously any operative procedure aimed at increasing survival would benefit a significant number of people. The use of another-look operation in the management of colon carcinoma has afforded close correlation between the anatomical disease state and new noninvasive tests.

Case Presentation

The patient is a 61 year old white lady who presented to the University of Nebraska Medical Center in May 1977. Three years before she had undergone sigmoid resection for a well differentiated adenocarcinoma. Her lesion was classified as a Duke's Class C, with one mesenteric implant. Her new complaint was nonspecific abdominal pain present for one week. Physical exam revealed no suspicious abnormalities. Radiologic examinations of the gastrointestinal tract including air contrast barium enema revealed no abnormalities. Endoscopy demonstrated only a benign polyp in the transverse colon. Peritonoscopy under local anesthesia was normal. Liver-spleen scan demonstrated no anatomical defects. Liver biopsy showed microscopic evidence of fatty metamorphosis. Liver function tests were mildly abnormal. Carcinoembryonic antigen (CEA) was elevated to 17.6 ng/ml and 21.9 ng/ml. Prior to this hospitalization the patient had not had a CEA determination performed.

Another-look operation was performed for the following indications:

1. Good operative candidate without major concomitant disease.
2. Original lesion was classified as Duke's C with spread from the bowel.
3. Original curative resection was 36 months before and there was no obvious evidence of persistent disease.
4. CEA was elevated.
5. Unexplained abdominal discomfort.

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At operation the colon, small intestine, and stomach were normal. The mesenteries of these organs were not involved with persistent disease. The liver had a solitary nodule along the posterior surface of the lateral segment of the left lobe. Left lateral hepatic lobectomy was performed. The pathologic specimen was a six centimeter by three centimeter nodule containing mucin-producing metastatic adenocarcinoma.

Currently the patient is well. CEA levels have shown progressive decline and stabilization at the present level of 3.5 ng/ml.

Materials and Methods

The presentation of the above case initiated a retrospective review of patients seen at the University of Nebraska Medical Center with colon cancer. Fifty-five patients were seen over a 42 month period. During this time 15 patients underwent another-look operation. The majority of these operations were for treatment of concomitant disease and afforded renewed observation of the colon carcinoma state. Indications for operation included abdominal mass, incisional hernia, obstructive jaundice, acute abdominal infection, bowel obstruction, abdominal pain, peptic ulcer disease, rising CEA levels, and multiple polyposis of the remaining colon.

TABLE 1

Original classification after primary operation	another-look operation results		
	palliation	attempted curative resection	no recurrence
Duke's A	—	—	—
Duke's B	—	—	1
Duke's C	3	6	2
Duke's D	3	—	—

Results

Six patients who were originally classified as Duke's Class C underwent measures for curative resection at the another-look operation (Table 1). CEA levels were elevated in 12 of the 15 patients. Normal levels were found in the three patients who subsequently demonstrated no recurrence. Ultrasound demonstrated persistent lesions in five patients who had no evidence of disease by standard roentgenographic exams. Major complications developed in one patient and minor complications were seen in eight (Table 2).

TABLE 2

Complications following another-look operation

Wound infection/seroma	3
Cardiac arrhythmia	2
Pneumonia	1
Urinary tract infection	1
Upper gastrointestinal hemorrhage*	1
Short bowel syndrome	1

*major complication

Two patients died, both were in the unresectable-palliative category and were operated on for concomitant life-threatening problems. One patient who was receiving chemotherapy before another-look operation was deemed cured and further treatment was discontinued.

Discussion

The second-look operation introduced by Wangenstein in 1948 has not been embraced universally. Disfavor for continuing to use

this operative approach developed when the main goal of increasing survival in Duke's Class C colon cancer patients was not realized. Indeed 52% of patients had undergone unnecessary operations with no persistence found. The operative mortality was 5.8% and the small salvage rate of 14% was disheartening. The timing of reoperation was unselective and arbitrary.^{2,3}

New methods of identifying high risk patients are now being developed and include serial CEA levels and ultrasonography of the abdomen. The above review and case presentation helps to evaluate the use of these new modalities.

Patients were placed in the category of another-look if they had undergone an abdominal operation subsequent to their original resection. All patients were classified according to Duke's pathological classification.⁴ (Table 3)

TABLE 3

Duke's Classification

- Class A —
Lesion confined or limited to mucosa
- Class B —
Lesion involving muscularis or full wall thickness
- Class C —
Regional lymph node or mesenteric metastasis
- Class D —
Distant metastasis to liver, lung, bone or brain

It can be concluded that CEA assay was a reliable index of tumor persistence in our patients. All patients with persistence of tumor had elevated CEA. All our patients

without persistence had normal CEA levels. Not all patients had serial determinations but in those who had progressive increases on two consecutive occasions, persistence of tumor was present. Similar data obtained on a routine prospective study has been reported by Holyoke and others.⁵ Elevated CEA levels alone were responsible for undergoing extensive evaluation and subsequent operation in two patients in our series even though they were in an asymptomatic state.

Secondly, ultasonography has also improved the ability to identify hidden tumor persistence. In the 6 patients with resectable persistence of tumor only two had intraluminal lesions seen on barium study. 3 of the remaining 4 patients had extraluminal persistence which was identified by ultrasound. This modality affords examination of mesenteries, retroperitoneum, pelvis and liver. The use of CEA and ultrasound should increase the chance of detecting persistence of tumor in the early, resectable state.⁶

Thirdly, timing of operation has also been more sharply defined with utilization of these simple noninvasive exams. 21 months has been reported as the mean time interval between initial resection and symptoms that suggest persistence of disease.^{7,8} Our group had 5 patients with resectable persistence of disease discovered at twelve months after initial resection. These discoveries were initiated by rising CEA levels and suspicious ultrasound examination findings. A sixth patient did not demonstrate persistence until 36 months after initial resection. All of these patients had discovery of disease at a time when operation was beneficial. In these patients, it is likely that exploration six months after the initial resection would have missed the residual disease.

Survival in our patients has been followed from 9 to 40 months. Five of the 15 patients have expired. In the group of 6 patients who were reoperated for cure, 4 are alive. Two

patients have expired from persistence of colon carcinoma.

Summary

Another-look operation in the treatment of colon carcinoma is useful in an effort to convert Duke's Class C patients to the tumor free state. Selection of patients and timing of operation can be adjusted by following CEA titers and abdominal ultrasound.

CEA levels should be obtained before the initial operative resection. Postoperative values should then be measured at 4 days and then every 2 months for 2 years. Without evidence of persistence, levels should be obtained every 4 months for the next 3 years and then every 6 months for life. Ultrasound at the time of CEA titer elevation and yearly examination of the colon alternating barium enema and colonoscopy should also be instituted to detect early persistence or new tumor in these high risk patients.

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Units of Intelligence

ABSTRACT

The intelligence quotient, or I.Q., is obtained by dividing the mental age by the chronological age, and multiplying this fraction by 100. It applies to children, for whom the concept of the I.Q. was invented, but we do not divide an adult's mental age by chronological age, so that this fraction does not exist and is entirely without meaning. The concept of measuring intelligence is sound, but it seems proper to stop pretending that the I.Q. is 100 times a fraction that is never used in the adult.

It is suggested instead that intelligence levels be measured in the adult by the usual tests, but that the term "intelligence quotient" be done away with, and that intelligence levels and intelligence units be used instead.

THE intelligence quotient has been with us for a long time, along with the idea that some people are more intelligent than others, and that intelligence can be measured.

It began with children, and if a four-year-old does what is expected at six, we divide six by four, and multiply that by 100, and so arrived at an I.Q. of 150.

Children grow mentally and physically, while adults may not. Adults have mental levels and they are given intelligence tests, and the I.Q. is applied to them, too.

Since intelligence is measured along with everything else that is considered quantifiable, I suggest that we abandon the concept of the intelligence quotient, and substitute the unit of intelligence in its place. Mental age divided by chronological age does not apply to the adult. The I.Q. was invented for children, and it is a meaningless arithmetical exercise in the grownup, to whom it is applied daily without justification.

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Let us discard the intelligence quotient, and speak of intelligence units instead. Let us say, not that my intelligence quotient is 137, which is obtained from a fraction that does not exist, but rather that I have 137 intelligence units or that my intelligence level is 137.

Let us stop pretending that an adult is capable of doing things that are to be expected only of someone ten years older, and do away with a fraction that does not exist in the adult (mental age divided by chronological age), and one that is completely without meaning.

Measuring requires units, and what are the units of intelligence? One unit of weight is the pound, which is a unit of force and of mass, and tells you how strong is the attraction between the earth and something you are lifting. But it is as difficult to define force as intelligence. Units of energy, distance, temperature, and volume are no better. At the end, we are left with units that are arbitrary and defy definition, excepting for loose concepts, as in our ideas of time and space.

Since one person may be more intelligent than another, there are amounts of intelligence, and where there are amounts, there are units. The quantity of intelligence possessed by the average individual is unity, or one, or one average amount. The average person has obviously an average amount of intelligence, or one average-amount or one average-unit of intelligence. If we prefer larger numbers and the percentile system, we may call the average 100, without pretending that we are, as adults, dividing our mental ages by our chronological ages, which we are not doing, and which no adult does.

Research Without Bounds

Student Research Forum
University of Nebraska Medical Center
November 11, 1977

IT is my purpose here today to provide you with some uncommon answers to a commonplace question, namely, how valuable is medical research? Ordinarily, our answers tend to be predictable. Like the public at large, we are apt to view research as a rather remote touchstone for continued progress in medical science and technology, a kind of abstract generator of the successive clinical improvements that have been delivered to patients.

And, of course, research does have great and enduring value as a touchstone for medical progress, and a generator of clinical improvements. Added health and life for patients is the ultimate goal of our respective professions . . . and research has enabled us to make many long strides in pursuit of that goal. And certainly those of us who work within the medical system, including the students in this audience, can readily recognize the value of research in terms of what new tools it has given us in the battle against injury, disease, and death.

These tools include wonder drugs, computers, cardiac pacemakers, carbon dioxide lasers, nuclear medicine devices, intensive care units, computerized axial tomography (or CAT scanners), automated lab equipment, and defibrillators, respirators, and resuscitators, to mention just a few. Meanwhile, during the past few decades, an explosion of new biomedical knowledge has occurred, an explosion so powerful that it has laid bare some of the last secrets surrounding the creation of life itself. We are now witness to the cellular chain reaction that creates a living, thinking, feeling human being. And along the way, we have gathered an immense amount of new clinical knowledge concerning the diagnosis and treatment of the medical problems that afflict patients.

Taken together, such advantages enable us

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to provide the best kind of medical care to patients. The quality of American medicine, in fact, has become an international benchmark, as medical experts the world over agree. But progress has a way of creating its own unique problems, and certainly this is true in medicine.

To begin with, while the quality of modern medicine is superb, it costs a great deal of money. So considerable controversy has cropped up around the socioeconomic and political dimensions of medicine, as various nations, including our own, try to strike a reasonable balance between the cost and quality of, and access to, medical care.

And certain related problems have been created in terms of our perception of — or perhaps I should say lack of perception of the crucial significance of medical research. This lack of perception is characteristic of health professionals and average citizens alike. Even within the medical system, the onrushing flood of scientific and technological discovery has fostered an ideological gulf between researcher, educator, and practitioner. What is medicine without research?, one faction says. Education holds the greatest reward, says another. Research and education are fine, says a third. But who is to care for the patient?

And this ideological gulf, this clinical isolation, has assumed other shapes. We have divided many times the confines of the human body, one part from another, each with distinct medical boundaries. Hence specialists tend to be isolated from one another. And taken together, the specialists, in turn, are isolated from the generalists.

And today medical care is delivered in professional installments, by a team, with each member of the team exercising singular responsibilities.

And this has resulted in some serious difficulties in terms of deciding precisely **who** should be doing precisely **what** for each patient. So it is that our respective professions tend to be scientific strangers, and each of us tends to go our own professional way. Little wonder, then, that we may forget just how valuable research really is to our own future, and the future of our professions.

To demonstrate that value, I'm going to turn to a book published in 1972 entitled, **The Power and the Frailty, the Future of Medicine and the Future of Man**. The author is Dr. Jean Hamburger, the distinguished French physician, researcher and medical educator. Dr. Hamburger underscores the dangers of regarding medical research and practice as separate and distinct. As he points out, the quality of the health professional depends on the quality of the sources from which new medical knowledge is acquired. And the quality of these sources, in turn, depends on the quality of research. Thus Dr. Hamburger concludes, and I quote: "Throughout the world, the quality of applied medicine increases in direct proportion to the quality of the hospital and university centers in a particular nation. And these centers will know how to move properly from theory to practice only if they are staffed by researchers."

Now the fact that our society, in the past, has vigorously supported medical research explains, in large part, why the quality of American medicine is unsurpassed. It also explains why you and I can expect to count ourselves among the most highly qualified health professionals in the world. Therefore, it behooves us to appreciate the critical importance of research, not only in terms of our present knowledge and skills . . . but also in terms of fulfilling our future professional potentials. And any failure to do so on our part obviously is inimical to the best interests of patients, as well as our own best interests.

Moreover, such failures also reinforce certain ominous changes in the way the general public currently approaches medical research. To begin with, there is an alarming tendency on the part of subsidizing agencies, especially government, to demand that all

research subjects and projects be precisely targeted.

Actually, this is understandable. To quote Dr. Hamburger once again: ". . . administrators like to be assured that such investigations will meet the demands of the struggle against the diseases that show up most frequently in the annual statistics." But while this may reflect the immediate interests of the general public, it is a gross oversight in terms of effective research, as Dr. Hamburger points out. Much of our knowledge about human genetics, and the transmission of hereditary diseases, for example, derives from studies completely unconnected with the diseases themselves.

These studies, in fact, were aimed at such plants as four-o'clocks, snapdragons, corn, or green peas, and at animals such as certain butterflies. And if these researchers had been forced to study hereditary human diseases per se, it is almost certain that we would lack much of the knowledge we now have, including some useful information about that most feared of all diseases — cancer.

Another striking example, one with important implications for my own ob-gyn patients, can be found in my home town. The McDonnell corporation, which is based in St. Louis, helped build the first U.S. space capsules, and the sophisticated telemetry equipment used to monitor the vital signs of astronauts while in flight. And a St. Louis pediatrician, Dr. Paul Byrne, convinced the corporation to adapt this space-age technology to the perinatal care of mothers and infants resulting from high-risk pregnancies. The result was early support for the development of Perinatal Intensive Care Centers which today provide superb care to infants at risk, including premature infants who would otherwise die. Lest I be accused of oversimplification, I should add that it will take many years to determine precisely how effective such centers are in fostering the growth of healthier infants. Even so, it should be obvious that research applications beneficial to patients often evolve from outside medicine itself.

And while applied or targeted research is important to the medical future of our

society, so is basic research, or research without bounds — government or otherwise. A related problem is that crippling variations can occur in terms of the priority assigned research projects, and hence in terms of the funding of these projects. This or that disease may be singled out as a research target in one session of Congress, for example, only to become a forgotten issue in the next. And erratic funding inevitably leads to erratic results.

In that respect, we must take particular care to avoid using a cost-benefit ratio as the primary determinant in assigning research priorities. The fact that this danger is both real and present has been attested to by Warren G. Magnuson, Chairman of the Senate Health Appropriations Subcommittee. In a recent article in *Parade* magazine, Senator Magnuson, who has crusaded for medical research in Congress since 1950, commented, and I quote: "It's the toughest job in the world to get Congress to vote the money for pure research. Congressmen are apt to say, 'What have you got to show for it?' Well, sometimes we don't have much to show for it. We just know that it has to be done if we are to make headway in applied research."

I should add that sometimes we can justify research expenditures on economic as well as humanitarian terms. Because of the development of polio vaccine, for instance, the nation has saved billions of dollars in terms of the costs of medical care which otherwise would be required. And similar cases could be made for chemotherapy effective against diseases such as tuberculosis, pneumonia, and diphtheria.

Nevertheless, subsidizing agencies — including Congress — should understand that there are no guarantees, no easy roads to success, in medical research. And while Congress has a responsibility to see that public funds are spent wisely, it should place considerable reliance on the advice of research experts, not to mention the advice of enlightened colleagues like Senator Magnuson.

In any case, I have attempted to sum up for you some of the promises and the problems of biomedical research, as well as

its intrinsic value not only to patients, but to our own professional futures.

And therein can be found the shape and the substance of the American Medical Association's responses to medical research issues. Our Education and Research Foundation, for example, in addition to its support for medical students and medical schools, has funded for a number of years now research forums for the American Medical Student Association.

And, on occasion, AMA-ERF has made limited funding available for the completion of specific research projects. Furthermore, our parent organization, the AMA itself, has a long record of staunch support for research. In 1971, the AMA House of Delegates fully supported the development of the kind of Perinatal Intensive Care Centers that I discussed earlier. And three years ago, in 1974, AMA Delegates adopted a biomedical research report reflecting the concerns that I have mentioned here today. Among these concerns, the report includes the following:

The need for adequate funding — public and private — of basic or pure research as well as applied or targeted research.

The need to eliminate federal funding variations based on political expediency.

The need to keep the operation of the National Institutes of Health flexible and creative, and free of arbitrary political influences.

And the need for sustained federal funding of medical research at a level proportional to the nation's total expenditures for medical care.

In closing these remarks, let me emphasize that the AMA report also underscores another priority, namely an adequate number of trained personnel to carry on with research. Unless we train enough research personnel today, then the quality of our medical tomorrow will be bleak.

It is my fervent hope that some of you will elect to make that future brighter, by engaging in research, research without bounds. Whatever your future careers, however, none of you should forget the crucial value of research to our patients, to our professions, and to ourselves.

Neonatal Thyroid — Screening for the State of Nebraska

THE mass neonatal thyroid screening programs of Oregon, Pittsburgh, Quebec, Toronto, and New England have provided data establishing the incidence of congenital hypothyroidism from 1/3000 to 1/7000 live births.¹⁻⁶ The national frequency of phenylketonuria is 1/14,300.⁷ These important findings suggest congenital hypothyroidism is the most common metabolic cause of mental retardation. Unless treated before the age of three months Klein et al have shown 85% of these children will have irreversible mental deficiency; if treated earlier, 70% of patients attain an IQ of greater than 85.⁸

Early diagnosis of congenital hypothyroidism by clinical features alone is difficult. Hence, the need for a program to screen for, and prevent the severe mental retardation caused by congenital hypothyroidism has been recognized and already become mandatory in many states. In recent months recommendations for screening programs for congenital hypothyroidism have come from the Committee of the American Thyroid Association and the Task Force on Genetic Screening.^{1,9}

The purpose of this article is to emphasize the already known needs in the State of Nebraska for neonatal thyroid screening and to review the criteria for an effective thyroid screening program. A centralized screening program would offer the advantage of a) standardized rigorously controlled T_4 testing, that can reassure the pediatrician of satisfactory laboratory data b) address the incidence of false positive results and attempt to reduce to the lowest possible number and hence c) avoid the psychological trauma to the family of an infant with a false low value and d) provide strict criteria for treatment of congenital hypothyroidism. If the trend continues to be one of individual hospitals providing this service in Nebraska, the pitfalls of a thyroid screening program must be recognized.

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An effective screening program must a) be sensitive enough to detect all abnormalities b) be specific enough to exclude false positives.⁹ If a state or hospital laboratory is to consider screening for hypothyroidism these important factors should be considered in the standardization of the T_4 test. The desire of any screening program is to have the lowest number of false negatives, and false positives. To achieve this, a rigorously standardized T_4 assay in addition to a TSH back-up assay is necessary for an effective screening program. The Task force on Genetic Screening has stated the commercial T_4 test does not afford the physician the essential statistical resource for interpretation in newborn infants. A well standardized and preferably centralized laboratory handling many samples will allow for the best sensitivity and specificity.

Further considerations in the establishment of a screening program should be a) a standardized means for data collection with follow-up data on all infants notified because of a low T_4 and/or low T_4 high TSH, or low T_4 low TSH value. b) psychological testing at yearly intervals for the affected infants with congenital hypothyroidism. If the diagnosis and treatment of infants with congenital hypothyroidism is left with the general pediatrician and practitioners provisions must be made for:

1. Adequate treatment of congenital hypothyroidism.
2. Differential diagnosis of primary, secondary and tertiary hypothyroidism.
3. Interpretation of thyroid function tests.
4. Recognizing side effects of thyroid treatment.

Prevention of the irreversible sequelae of

congenital hypothyroidism requires not only early detection but adequate therapy and follow-up. The preterm and stressed neonates have lower T_4 values.¹⁰⁻¹⁴ If a program utilizes only T_4 values a very high number of false positives will occur within this group. A backup serum TSH assay will protect against false positives in this group. To screen these infants without TSH backup will create problems. In the screening programs thus far using the filter paper T_4 methods, approximately 1% of samples require retesting due to false positives, and 2.0 to 2.5% require retesting when cord blood alone is used.⁵ All the congenital hypothyroid patients detected in the Quebec screening program had T_4 values >2 SD below the geometric mean for the days samples. Of these patients, 85% of the cases resulted from primary thyroid failure and subsequent elevation of serum TSH values.

The remaining 15% were hypothalamic pituitary deficiency states or inborn defects in thyroid hormone biosynthesis. This justifies further the need for both T_4 and TSH assays.

These suggestions have been made to aid in the development of a reliable neonatal screening program for the state of Nebraska. As suggested by the Task force on Genetic screening, "measurement of serum T_4 values alone in the newborn does not constitute a screening program for neonatal hypothyroidism."⁹ The integrated approach to neonatal thyroid screening consisting of standardized testing, rapid diagnosis and follow-up, and adequate management has been the most effective approach found in other state thyroid screening programs.

References may be obtained from the author.

My 50 Medical Years

I was graduated from the University of Nebraska College of Medicine, on June 4, 1927. My premedical education was at Creighton University in Omaha, 1921-23 after graduating from high school at Fremont in 1920. Licensed, August 13, 1927.

I served as senior student intern at St. Catherine's Hospital, Omaha from 1926-1927. I was house physician at the same hospital from 1927 to 1928. Served a locum tenum at Beemer, Lyons, Hartington, and finally located at Brainard, Neb. in 1929 where I was also a member of the David City hospital staff. I served as Selective Service examiner 1941-42 for Butler County. I relocated in North Platte in April 1942, and continued practice here until retirement in Jan. 1974.

From 1942 until retirement, I served on the hospital staff of both St. Mary's and Memorial Hospital in North Platte. I also was on the staff of the Union Pacific Railroad for the same number of years. I served all offices of both Butler and Lincoln County medical societies, as well as David City, St. Mary's, and Memorial hospital staff positions.

O. C. KREYMBORG, M.D.

I was repeatedly rejected by all services during W.W. II and the Korean conflict, due to my physical handicap of being 6 ft. 9 inches in height and weighing 185. No waivers would be accepted.

I have enjoyed general practice with surgical privileges, also an extra amount of obstetrics throughout my 47 years of practice. I retired because of physical disabilities, sight predominately. I have had the privilege of officiating over 3,000 deliveries. An accurate count is not available, due to missing records.

My most notable obstetrical patient: 10 successful Cesareans, all children living, classical procedure. The last two were recorded with color movies.

In reply to a statement of account, I received this reply: "Dear Sir: I will make a payment on this account just as soon as I can. So please be passionate."

To accommodate a friend of mine, I made a medical call at our leading hotel. The patient was the real John L. Lewis, bushy brows, and all. I still have the five one dollar bills with his signature across the face as payment for the call. He refused to autograph a Rx blank, stating he had no authority to sign his name on such a blank.

In answering a rural call once to treat a farmer's daughter for abdominal cramps and backache, I delivered an illegitimate baby boy, successfully relieving the patient of her pains and aches. While in the kitchen washing and drying my few instruments prior to packing my OB grip, I found the patient's father sitting in a chair facing the back door, loaded shotgun in lap, and repeatedly saying, "I'll get that s.o.b." To my knowledge he never was successful.

I had the privilege(?) of practicing Federal Security Administration government medicine during the depression. I was also the county medical society secretary during that period. I administered the intake money. Result: the doctor was on the lower end of the totem pole for medical fees, just about one step above total charity. The hospital and medications came first, doctors got what was left equally divided as to total fees rendered each month. What an introduction to federal medicine!

I still have my state alcohol permit allowing me to buy 5 gallons of grain alcohol per year for office purposes. The permit is signed by then Governor Charles Bryan. No one ever checked how this alcohol was used.

While serving as senior student intern, I received my first medical fee. Legally it was a gift. In rendering ward service to an alcoholic brought in by the police paddy wagon, and in being dismissed, he took from the lining of his shoe, a \$2½ 1878 gold piece, I still have it. The following Christmas he brought me a Stetson hat as a gift — my first.

This being the 50th anniversary of Lindbergh's flight, I well remember his visit to Omaha. An immense crowd was at the airport. A moving freight train adjacent to the field engulfed some of the spectators. A police ambulance brought in a female victim covered with a bloody sheet. An attendant

reached under the sheet and brought out a near-total leg which had been amputated by a train wheel. He simply handed it to a senior nurse who was totally dumbfounded as to what to do with it.

A noted cardiologist had an extensive medical practice at one hospital. One morning during breakfast, six of his patients expired. I recall hearing the senior student nurse on the phone telling him to get to the hospital, as he was rapidly losing his practice.

I had the privilege of serving under Dr. Crummer in the experimental use of Eli Lilly liver extract, and under Dr. Frank Conlin in the original use of insulin. What a break-through in therapeutics! Who ever dreamed of the total therapeutic change-over to occur 25 years later.

As a city kid, I was dumb in many rural events. The first baby I delivered in a farm home was accompanied by the incubator hatching process. Result: delivering baby chicks is easier! Once when tying the cord, I completely severed it, and it was necessary to clamp the cord stump with hemostats. Twenty odd years later, this baby came to show me her pretty navel.

I served 32 years as a Union Pacific surgeon in North Platte. My most interesting case was that of a car man being struck by a moving switch engine and witnessed by a group of Navaho Indians. The car man was severely contused and abraded, his bald head was untouched. Later one of the Indians reported to his superior that he witnessed the accident and the victim had been scalped! He then proceeded to hand over the victim's toupee! (That explained why his bald head had never received a scratch!)

Another case that is well remembered. A switchman was run over by a moving box car, the result was total amputation of right arm at shoulder, the right leg, at groin, the left leg, at ankle. After long hospitalization, a \$750,000 settlement.

While a senior student intern, I assisted Dr. Wm. Taylor. He did a version extraction for lateral placenta praevia while the 10 o'clock Nebraska power plant whistle was blowing. Yes, I have done several versions

on the kitchen table — obsolete practice today!

During the war I answered a night call at the bus depot. A female patient was taken to the hospital and delivered. I later found out hospital policies did not pay for obstetrical cases unless one was married.

I took a German scientist off a troop train going to Los Alamos late in the war. He was a team member of the original German missile section and a war prisoner. The diagnosis, a ruptured gastric ulcer. The surgical repair successful. Aspirated five gallon "beer like liquid" from abdomen before peritoneum incised. His fellow workers stated that beer was his total diet while on the train.

Following a family tradition, I became a volunteer fireman in May, 1929, at Brainard, Neb. My great grandfather, my grandfather, and my father, were all volunteers. Early, I became a Red Cross and state vocational education First Aid teaching pioneer. This instruction hobby has continued until the present.

Becoming a member of the State Volunteer Association in 1932, I campaigned for an educational program for volunteer firemen. The result, in 1939 under state vocational-trade, industry section, a state program of itinerant instruction evolved, and is still in operation. In conjunction, a State Fire School was instituted in Grand Island. This is held in May each year, and involves about 1200 to 1400 students for three day's instruction. For 35 years I have taught a 12 hour class on

"Emergency Care" at this school. Due to this connection, I have taught in the eleven midwestern states over 200 classes on "Emergency Care" in their annual state fire schools.

Associated with this instruction activity, I have become a contributor to the Rescue and Fire First Aid Instruction manuals, published by the International Fire Service Training Association at Oklahoma State University. I contribute the section on Obstetrics. These 20 total manuals are the universally used instruction books for the entire fire service all over the United States.

I have been a contributing editor to the "Fire Chief" magazine, circulation 23,000, published in Chicago, and distributed to all Fire agencies in the United States and Canada. So far, I have contributed 200 monthly articles on "Emergency Care."

Because of this emergency care interest, I have been on the original medical liaison committee of the International Fire Chief's Association, the International Fire Fighter's Assoc., etc. to study the medical-surgical problems and health of firemen. I represent the volunteer firemen.

I was president of the state association for two years, 1945 and 1946. I recently completed my 47th year as a volunteer.

After 56 years of smoking one to two packs a day, I discovered a quick-stop method — I successfully underwent an abdominal aortic aneurysmectomy in March, 1976, and haven't smoked since.

Down Memory Lane

1. All doctors, whose practice has much to do with children, look with dread upon the disease, infantile paralysis.

2. It is a truism, demonstrable, that nothing destroys muscle faster than non-use or, as an article in one of the health magazines put it tritely, "Use 'em or lose 'em."

3. The prolongation of the span of life by preventing the untimely death of children and the youth has brought correspondingly an increase in the number of the aged subjects and these the physician is called upon from time to time to care for.

4. When the pneumonia patient becomes septic very little can be done.

5. Do you know that your hospital to be accredited by the A.M.A. now must have 15% of all deaths autopsied?

6. In the later eighties the two physicians then occupying the field must have had seventy-five cases of typhoid to treat one fall.

7. I delivered her of a dead foetus with forceps — and am still waiting for my fee.

8. One of the most important factors to be remembered in connection with gastric ulcer is the ever present danger of malignancy, which may be disregarded in the duodenal ulcer.

Nebraska State Medical Journal
August, 1928.

President's Page

WHAT IS COST CONSCIOUSNESS?

WHAT IS COST CONTAINMENT?

WHAT IS COST CONTROL?

WHAT IS COST EFFECTIVENESS?

When will we learn to contain health care costs? What are health care costs? The American public is so fortunate to have over 50 regulatory Federal Agencies looking after its health care dollar so that each dollar does its fair share and is not wasted. You, a member of the ancient honorable respected profession of healing — why don't you listen? — Why don't you save your patient and his insurance company — especially if it's a medicare patient, some money — Hell — he might even pay your bill. This is cost consciousness!

The goal of reducing health care costs was 2% a year. 1976 health care costs were 19.5% over 1975. 1977 was 15.5% over 1976 and first quarter 1978 13% over 1977, a reduction of 6.5% — not 2%. This is confirmed from AHA by Blue Cross, Blue Shield, the Federal Budget Office, HIAA, and the Bureau of Labor Statistics. This is cost containment!

Your supreme commander — the Honorable Joseph C. Califano is just now finishing the swine flu fiasco. Remember the vaccine that the M.D.s said was unneeded and the drug companies didn't want to produce so rapidly because they would not be able to do quality checks on their product, but HEW wanted the "generic" in the people — well — up popped Guillain Barre. Now your leader will settle out of court all claims — the claims only amount to three quarters of a billion dollars — do you think that is bad? This is cost control?



The 23 member Senate Finance Committee is hearing S1470 — the administration's cap bill. Would you believe that a vote for the administrations bill would result in a small 10-20 million dollar federal project in that Senator's home state — maybe he could get his name on the unneeded nonecologic dam if he could influence some one to vote aye. This is cost effectiveness?

Well — Run that through your PSRO. Run that through your utilization review committee, but damn — wake up — save those health care dollars.

Houtz Steenburg, M.D.



The Auxiliary

ADDRESS TO THE HOUSE OF DELEGATES, MAY 3, 1978

As a group of dedicated auxiliaries, we are proud of medicine, our husbands, and their role in our society. We are anxious to promote the kind of image that tells others we care about what happens in the field of Legislation, Health Education, Youth Services, Health Careers, Immunization, Alcoholism, Drug Addiction, Senior Citizen's Services, etc. I wish I could share with you the county reports which I have received this month. These tell the story about the kinds of social concerns which involve doctor's wives in Nebraska as volunteers. They work in hospitals, establish GEMS programs, sponsor Child Abuse and Rape Seminars, become actively involved in Crisis-Lines, promote medicine's views in high school debates concerning socialized medicine, take Talking Books to the blind and physically handicapped, and perform many more services where there is a need. May I urge you to avail yourself of the opportunity to look at our Project Bank which is published nationally, and which lists more than 500 programs which doctor's wives promote wherever they are involved in an auxiliary. We are responding to the needs of people in many and diverse ways.

Legislation continues to be an important emphasis in auxiliary. This year we were invited to attend your Medical Services Committee meeting. Our Legislation Chairman, Mrs. Robert Lovgren, has kept abreast of issues and bills and sent innumerable letters to county auxiliaries whenever there was a need for their support. This included using LEGS Alert in two different instances. In March, our state auxiliary entertained five senators at a luncheon meeting at the University Club in Lincoln. Thirteen doctor's wives also came, one from as far away as Norfolk. Legislation continues to be one of our priorities, and it is our deep desire to be supportive of you whenever you feel we can help.

In Nebraska, our state auxiliary raised in excess of \$5,000 for AMA-ERF, under the leadership of Mrs. Lyle Nelson, Chairman. Each county could raise this money any way they chose. We are anxious to continue and expand the program as the need for more money for medical education and research is increasing. It is also hoped that the county auxiliaries will continue to respond and double their support for the Nebraska Medical Foundation with money raising projects.

The Advisory Committee met in the fall and again pledged the support of the Medical Community in the fund raising drive for the Health Gallery. It was at this meeting that the Center Fold and Pledge Card, promoting Health Gallery, was approved for the December issue of the Nebraska Medical Journal. Health Gallery is one of our priorities in Nebraska Medical Auxiliary at this time. Helen Hayes continues her effort to enlist the financial support of all doctors in Nebraska. She is one of the most dedicated volunteers in our state program. She works closely with Dr. Ian Neumann of the University of Nebraska Dept. of Health Education and with the University Foundation, assuring herself and us that we are included in all planning and are given proper credit for all funds raised. She spends hours of her time and talent writing letters, attending meetings, and promoting the whole fund raising effort of the Medical Auxiliary. We are now assured of reaching our goal, and we greatly need your continued support to finish the job.

Communication has been my emphasis this year. Flyers have been sent to **ALL** doctor's wives in Nebraska, regardless of membership. We want this way to reach many more ladies with the hope they will choose to join us. Our potential in Nebraska is many more than our present membership of 804. With a deep desire to tell the real story of medicine and doctors, we invited two newspaper reporters and a TV program director, to our Fall Board Meeting. We hope it was apparent to these people that our major

interests are neither bridge nor parties. We are deeply grateful to Dr. Frank Cole for his continued cooperation in allowing us a page in the Nebraska Medical Journal, and extra pages to list Health Gallery donors. We also hope Nebraska doctors will read what we write, for we attempt in this way to tell you about our programs.

As Auxiliary president, I have kept my car ready with a full tank of gas, my suitcase always handy, and my husband supplied with food from the refrigerator. My home has been my stopping place, and not my castle. Last June two other delegates and I represented Nebraska at the National Convention in San Francisco. In October, three of us traveled Nebraska, holding workshops in

Scottsbluff, Hastings, and Beatrice. Six other county auxiliaries were visited in the fall also. In October, four of us from our state auxiliary, President-Elect, Dorothy Shaffer, of Lincoln, Soldi Cutshall of Winside, and Barbara Peck of Hastings, and I attended the National Leadership Confluence in Chicago. This year our National Auxiliary paid round trip travel expenses to Chicago for six of our key people for training programs. In this and many other ways, they are sharing our national dues with us and all other states.

Dorothy Matson
President
Nebraska Medical Association Auxiliary
1977-1978



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P.O. Box 30186
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Make check payable to:
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Goal for support from Medical Community 150,000.00*
*House of Delegate action October 1976, recommended
that each physician donate \$200.00 over a three year
period.

70% of the \$150,000.00 has been raised
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listed in the Nebraska Medical Journal. All
monies raised will be used for the develop-
ment of the exhibits in the galleries.

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Our Medical Schools

Nutrition in children; U of N.

A nutritional biochemist with the University of Nebraska Medical Center and Swanson Center for Nutrition is conducting a study to determine the nutritional status of preschool children in day care centers and how it can be improved.

In a survey of children at 13 Kentucky day care centers, Dr. Jack Smith, director of the UNMC Division of Medical Nutrition Education and deputy director of the Swanson Center, has found vitamin and growth deficiencies in many of the youngsters.

Dr. Smith, who recently began a similar study with an Omaha day care center, became involved in the investigation at the request of Kentucky health administrators in the fall of 1976 when a federal nutritional surveillance program revealed that 20 to 30 percent of the preschool children in Kentucky were anemic.

With the help of a grant from the Swanson Center to Kentucky's Cumberland Valley Health District, Dr. Smith and personnel from the district and the state's Department of Human Resources examined blood samples from 250 children in the day care centers of Clay and Jackson Counties.

Dr. Smith and colleagues also surveyed the children's height and weight and discovered that 20 percent were shorter than the appropriate height associated with their ages, while 10 percent were heavier than normal.

To compare the effectiveness of the different supplements in improving the nutritional status and reducing the morbidity and absenteeism rates of the children, Dr. Smith divided the youngster into three groups, with the first receiving iron supplements, the second getting vitamin tablets and both supplements being given to the third.

In addition to his Kentucky studies, Dr. Smith directs a nutritional biochemistry laboratory at the Medical Center, which provides diagnostic services, conducts nutri-

tion research, supervises graduate students and participates in teaching nutrition to health professions students.

The laboratory's activities are supported through a grant by the Swanson Center to UNMC.

Gerraughty named at Creighton

Robert J. Gerraughty, Ph.D., associate vice president for Health Sciences at Creighton University, has been named to a steering committee of the Institute of Medicine, National Academy of Sciences.

The steering committee is responsible for organizing and conducting a major conference on the development and marketing of pharmaceuticals for the endemic diseases of the less developed countries of the world.

The conference, scheduled to take place the end of November, 1978, will cover two areas of major importance. First, the conference will address the scientific issues as they relate to the availability and characteristics of existing drugs and the requirements and opportunities for developing new drugs for the diseases of parasitic, bacterial and viral origin important in the developing countries.

The second area will be the range of important issues associated with the marketing of drugs in developing countries. Included will be the high and rising costs of drugs in low-income countries, marketing and distribution of inappropriate drugs, bulk purchasing, local packaging and distribution of existing and new drugs and establishing a list of essential drugs for these countries.

The project is supported by the Department of Health, Education, and Welfare and the Pharmaceutical Manufacturer's Association.

Last April, Dr. Gerraughty participated in a study sponsored by the Institute of Medicine in which he joined a group of 12 consultants in a month-long study of the

health care of Egypt. The study was requested by the State Department's Agency for International Development.

Counselors at U of N.

Eight Nebraskans have been selected to serve on the Board of Counselors of the University of Nebraska Medical Center.

The eight will work with the other 20 members of the board as a citizens' advisory group to Chancellor Neal A. Vanselow in the formulation of policies and community relationships.

The Board has been active in reviewing governance of University Hospital; strengthening research and scholarly activity in the Colleges of Medicine, Pharmacy and Nursing; and long-range planning.

Serving four-year terms are: Max Coppom, president of West Nebraska General Hospital, Scottsbluff; Janet Miller, past president of the Lincoln County Federation of Republican Women, North Platte; Phyllis Neuswanger, producer of audio-visual features (Neuswanger, Inc.), Alliance; Donald Treadway, Nance County attorney, Fullerton.

Serving three-year terms are: Leroy J. Schroeder, vice-president and general manager of Dorsey Laboratories, Lincoln, and Allen D. Strunk, publisher of the McCook Daily Gazette.

Gerald Beattie, grain and livestock businessman, Sumner; and June S. Schorr, membership chairman of the Irving Junior High School Board of Directors, Lincoln; will serve two-year terms.

Other members of the Board include: Eugene A. Conley, president, Guarantee Mutual Life Co., Omaha; Robert Daugherty, president, Valmont Industries, Valley; John Delich, president, Mutual of Omaha Fund Management Co., Omaha; John H. Frey, executive director, The Lincoln Foundation, Lincoln; F. Phillips Giltner, president, First National Bank, Omaha; Kermit Hansen, University of Nebraska regent, Omaha.

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Chest diseases.

Physicians and pulmonary health care professionals will have an opportunity to expand their knowledge of lung diseases during the Sixth Annual Midwest Conference on Chest Diseases, to be held October 8, 9, and 10, 1978 at the Hilton Hotel in Omaha, Nebraska.

Through workshops, panel discussions and lectures by a national faculty, participants will learn the latest information on the identification, diagnosis, management and physiology of various pulmonary disorders.

Except for a series of workshops which will begin the conference Sunday afternoon and presentations on Monday and Tuesday mornings, the program will be divided into two concurrent sessions, one specifically designed for physicians and the other for nurses and respiratory therapists.

In addition to health professionals from Omaha-area hospitals, program faculty will include such nationally prominent pulmonologists as: Dr. John E. Kasik, medical director of the Respiratory Therapy Services, Iowa City Veterans Administration Hospital and University of Iowa Hospitals and Clinic; Dr. Kenneth M. Moser, director of the Pulmonary Division, University of

California in San Diego; Dr. Irwin Ziment, chief of medicine at the Olive View Medical Center in Van Nuys, California.

With a registration fee of \$100 for physicians and \$40 for all others, the program is acceptable for 14.5 prescribed hours of continuing education credit by the American Academy of Family Physicians and 14 hours in Category I for the Physician's Recognition Award of the American Medical Association.

Course coordinators are Dr. Walter J. O'Donohue, Jr., chairman of pulmonary medicine at Creighton University School of

Medicine, and Dr. Irving Kass, head of the University of Nebraska Medical Center's Regional Chest Center.

Sponsorship is by the American Lung Association of Nebraska, Nebraska Nurses' Association, Nebraska Society for Respiratory Therapists, Nebraska Thoracic Society, Creighton University School of Medicine and College of Nursing and the University of Nebraska Medical Center.

Write to the UNMC Center for Continuing Education, 42nd and Dewey Streets, Omaha (68105), telephone 402-541-4452.

Welcome New Members

Patrick W. Bowman, M.D.
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Stratton, Nebraska 69043

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Omaha, Nebraska 68105

Between Cases

Section On Breast Cancer.

The mortality rate of carcinoma of the breast has not changed in over 50 years.

Words I Can Do Without.

Track record, algorithm, cap, mollification, divers, diverse, bastion, amongst.

Quote Unquote.

Medical men, particularly psychologists and psychiatrists, are notoriously imprecise and idiosyncratic with their jargon.

Howard.

Department Of Definitions.

Management: Interruptions interrupted by interruptions.

Anon.

Section On Change.

It follows that the appeal to the catch phrase "change means life" needs reconsideration. Change means death too, and in our own bodies we take steps to arrest or reverse certain changes by medicine, inoculation, surgery, and other strong measures.

Wilson Follett: Modern American usage.

Department Of Definitions.

Patience: A minor form of despair, disguised as virtue.

Bierce.

Section On Statistics.

Statistics are for losers.

A.D.

Quote Unquote.

I never think of the future. It comes soon enough.

Einstein, I think.

Section On Hyperacusis.

I can hear paint dry.

Definitions.

Insomnia: resisting a rest.

Anon.

The Physical.

Strength of flexion and extension at the knee is five over five, but reduced.

Quote Unquote.

When you come to the end of a perfect day, you can be sure it isn't over yet.

Anon.

OB GYN.

Ask a girl which she would choose, beauty or brains; if she says she'd rather be beautiful, she's got brains.

Anon.

—F.C.

Books



Basic & clinical immunology; edited by H. H. Fudenberg, D. P. Stites, J. L. Caldwell, and J. V. Wells; 758 pages; \$14.50, limp cover; published 1978 by Lange Medical Publications, Los Altos, California 94022.

This is the second edition; the book first appeared in 1976, and a third edition is planned for 1980, so that there can be no doubt of the publisher's and editors' desire to have the book up-to-date.

The text is divided into no less than 44 chapters; there is a good index; there are pictures, figures, and unnumbered references; and there is an appendix.

The list of 52 authors, including the editors (the editors are all MDs, but not all of the authors are) is imposing; some of the authors report from three foreign countries.

Each chapter has been revised since 1976, and new ones have been added. Transplantation is discussed in two new chapters. The print is good, and so is the writing, and reading is easy if you find immunology easy to read. The book is recommended.

—F.C.

Physicians' Classified

Advertisements in this column are run at a rate of twenty cents per word with a minimum of \$10.00 per insertion. Copy must be received by the fifth of the month preceding date of publication and should not exceed 50 words. Each advertisement will be taken out following its first appearance unless otherwise instructed. Where numbers follow advertisements, replies should be addressed in care of The Nebraska Medical Journal, 1902 First National Bank Building, Lincoln, Nebraska 68508.

PSYCHIATRIC RESIDENCY: Vacancies for (PG2 through PG4 only) positions starting September 1, 1978, and January 1, 1979, for those who have a regular Iowa license or can obtain one by reciprocity or via FLEX. Prepare for career in private practice, community clinics or hospital-based psychiatry. Emphasis on close supervision of intensive individual and group psychotherapy, OPD, Children's Unit, Adolescent Unit. Neurology affiliation with University of Iowa. The stipends are: 1st year, \$22,360; 2nd year, \$23,478; 3rd year \$24,674. Intensity and diversity of training program appreciated best by personal visit. T. B. McManus, M.D., Superintendent, Mental Health Institute, Cherokee, Iowa 51012. Equal Opportunity Employer. Call collect 712-225-2594.

FAMILY PRACTITIONER needed to join solo practice in Grand Island. \$30,000 guaranteed plus good fringes. Please enclose curriculum vitae. P.O. Box 872, Grand Island, NE 68801.

STAFF PHYSICIAN — General practitioner to perform general examination, care, and treatment of patients or staff at state psychiatric hospital. Surgery limited to emergency first-aid care. Forty-hour week with rotating on-call duty. Salary negotiable in range of \$31,387 to \$42,286. Excellent benefits. Contact: H. D. Herrick, M.D., Superintendent, Norfolk Regional Center, Box 1209, Norfolk, Nebraska 68701. Call Collect: 402-371-4343.

FAMILY PHYSICIAN NEEDED — 30 minutes S.E. of Omaha. G.P. with large practice moved to specialize. Office space available. Nearby hospital will offer financial incentive and staff will refer all local patients. Active established community with new \$35,000 ambulance with Life-Pak 5 and reliable hospital-trained crew. Contact D. Langone, D.D.S., Box 475, Malvern, Iowa 51551 or (712) 624-8634 (collect).

SIOUX FALLS FAMILY PRACTICE RESIDENCY is seeking a full-time assistant director. Position open immediately. Program size presently 28 residents enlarging to 36. A strong affiliation exists with the University of South Dakota School of Medicine and appointments to the faculty are available. Board certification required and experience in Family Practice desirable. Salary negotiable. Send resume to L. J. Sweeney, M.D. or Howard Hoody, M.D., 1800 South Summit Avenue, Sioux Falls, SD 57105. (605) 339-1783. Equal opportunity/affirmative action employer.

7-78

Coming Meetings

CRIPPLED CHILDREN'S CLINICS —

- July 29 — Norfolk, Elks Lodge
- August 12 — Scottsbluff, St. Mary's Hospital
- August 26 — McCook, Elks Lodge

NEBRASKA MEDICAL ASSOCIATION —

Fall Session, September 22-24, 1978, Lincoln Hilton Hotel, Lincoln, Nebraska.

RADIOLOGISTS MEET —

The Society of Gastrointestinal Radiologists is conducting a postgraduate course on "Diagnostic Imaging of the Gastrointestinal Tract" at Tan-Tar-A, Lake of the Ozarks, Missouri from October the 12th to October the 15th, 1978. The faculty will be drawn from the membership of the Society of Gastrointestinal Radiologists and includes leading academic radiologists from the entire country. The registration fee is \$225. The course is co-sponsored by the American College of Radiology with approval for category I credit of 13 hours. Further information and application materials can be obtained from the president of the society, Walter M. Whitehouse, M.D., Department

of Radiology, University of Michigan Hospital, Ann Arbor, Michigan 48109

OMAHA MID-WEST CLINICAL SOCIETY:

46th Annual Postgraduate Assembly; Omaha Hilton Hotel; October 30, 31 and November 1, 1978. Write to: Lorraine E. Seibel, Executive Secretary, Omaha Mid-West Clinical Society, 540 Medical Arts Building, Omaha, Nebraska 68102.

AMERICAN MEDICAL ASSOCIATION —

Interim Session, House of Delegates, December 2-6, 1978, Palmer House, Chicago, Illinois.

AMERICAN MEDICAL ASSOCIATION —

Winter Scientific Program, December 7-10, 1978, Las Vegas, Nevada.

NEBRASKA MEDICAL ASSOCIATION —

Annual Session, April 29 - May 2, 1979, Holiday Inn, Kearney, Nebraska.

AMERICAN MEDICAL ASSOCIATION —

Annual Convention, July 22-26, 1979, Chicago, Illinois.

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Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, tetracycline, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitroazanaphthal reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

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How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon. See package insert for complete prescribing information.

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Medicine*news*

Chronic lung disease.

Chronic lung diseases are becoming a greater health challenge every year, but patients who have emphysema, chronic bronchitis, and asthma are being helped to meet the challenge through a pilot research program being conducted at the University of Nebraska Medical Center's Regional Chest Center in cooperation with Blue Cross-Blue Shield of Nebraska and Medicare.

The program, which is the nation's only federally-sponsored research project devoted to the rehabilitation of lung patients, consists of 12 days of physical and psychological evaluation and health and vocational rehabilitation designed to meet each patient's specific needs.

Help is offered to all patients with chronic lung diseases said Dr. Irving Kass, Chest Center Director, but they are concerned mostly with helping those people between the ages of 20 and 60, and the older population over 65.

In establishing the 12-day program, the Chest Center has worked closely with the Biomedical Applications Division of the National Aeronautic and Space Administration in devising new rehabilitation techniques.

From preliminary tests, a diagnosis can be made which will determine what type of rehabilitation program will be designed for the patient by the Chest Center's interdisciplinary team of physicians, respiratory therapists, vocational and social counselors, psychologists and nutritionists.

If the exercise-stress test shows that the patient cannot meet the physical demands of his occupation, the patient may be referred to the State Division of Rehabilitation Services for vocational rehabilitation or to his employer for job modification.

Regardless of what type of rehabilitation the patient undergoes, the Chest Center program does not end when the patient is discharged from the hospital. The staff designs an individualized health care program which the patient can continue at home.

Write to Dr. Irving Kass, University of Nebraska Medical Center, 42nd and Dewey Streets, Omaha 68105.

Grant to Dr. Mirvish.

The American Cancer Society has awarded a \$37,932 one-year grant to Dr. Sidney Mirvish, a professor at the University of Nebraska Medical Center Eppley Cancer Institute, for his work with a group of cancer-causing substances known as nitrosamides.

Dr. Mirvish has been investigating the formation of nitrosamines and nitrosamides and how they are affected by ascorbic acid; he is studying the hypothesis that nitrosamides, which have been proven to cause cancer in animals, might be found in some foods or produced in the stomach.

Picture Gallery

NMA 1978 Annual Session



Doctor Russell L. Gorthey presenting Reference Committee report.



Doctor F. F. Paustian presenting Reference Committee report.



Doctor Stanley M. Truhlsen presenting Reference Committee report.



Doctors Charles W. Landgraf, Jr., Houtz G. Steenburg and Carlyle E. Wilson, Jr.



Mr. George Plimpton addressing audience at Athletic Medicine Luncheon.



Mr. George Plimpton addressing audience at Athletic Medicine Luncheon.



Scientific Sessions Committee Convention Chairman, Doctor Y. Scott Moore, introducing first scientific symposium.



Symposium moderator, Doctor Jerry A. Reed, and guest speakers, Doctor John V. Basmajian and Donald Marx, R.P.T.

Picture Gallery

NMA 1978 Annual Session



Mrs. Lyle H. Nelson, AMA Auxiliary AMA-ERF Chairman.



Nebraska Medical Foundation President, Doctor Louis J. Gogela.



Doctor Frank Cole, Editor of the NMJ, and NMA Past Presidents, Doctors O. A. Kostal, Roger D. Mason, Warren G. Bosley and John D. Coe.



Mr. Robert E. Houston, Mrs. Robert E. Houston and Doctor Louis J. Gogela.



Nebraska Medical Foundation President, Doctor Louis J. Gogela, presenting student scholarship check to Mr. and Mrs. Robert E. Houston.



Mrs. Lyle H. Nelson, NMA Auxiliary AMA-ERF Chrmn., presenting check to Doctor Perry G. Rigby, Dean, University of Nebraska College of Medicine.



Guest speaker, LCDR Michael F. Boyer, MC, USN; moderator, Doctor Y. Scott Moore and Scientific Sessions Committee Chrmn., Doctor Robert M. Stryker.



Mrs. Lyle H. Nelson, NMA Auxiliary AMA-ERF Chrmn., presenting check to Doctor Joseph M. Holt-haus, Dean, Creighton University School of Medicine.

An important message

Blue Cross and Blue Shield

We often refer to history to help solve many of today's problems. So let's take a brief look at the history of Nebraska Blue Shield.

This organization was organized by physicians for the benefit of the public. It was their method of countering government pressure for a national health insurance program. Obviously, physicians were concerned with their right to practice medicine in a self-controlled rather than a governmentally-controlled environment. They were more concerned, however, about the effect of a governmental program of such dimensions upon the health needs of the American public.

As a result, physicians formed Nebraska Blue Shield.

An organization that would make physicians coverage available to the public on a mass marketing basis, utilizing the group mechanism. And by meeting the everchanging needs of the general public, this voluntary prepayment arrangement still works.

However, we are faced again with the government wanting to replace the proven and successful voluntary system with another one that has been disastrous world-wide. And again, it's up to you, the physician and an organization, now known as Blue Cross and Blue Shield of Nebraska, to help prevent this unwanted intervention. And again, there's a realistic solution.

A solution that will not only help preserve the voluntary health care system, but, will, at the same time, satisfy the needs of physicians and their patients.

It's called the Physician's Voluntary Cost Effectiveness Agreement. An agreement which allows physicians to determine their own fees and assures them of fair and adequate reimbursement of their fees.

It's fair. Fair for everyone. And with your support...it can work.

So, study the information that was sent to you. Then call us if you have any questions. And if you have no questions...sign the Physician's Voluntary Cost Effectiveness Agreement and return it to us.

It'll be your personal effort in helping to maintain the delivery of quality care in a voluntary system that gives everyone a free choice.

Answers to some questions you may have

- What if the physician's usual fee is above the customary range, but the patient agrees to the specific fee before services are rendered?

In such cases of prior agreement, the physician can bill the patient for the balance.

- What if a physician has a disagreement and wants to appeal?

He can request review by either the NMA's peer review mechanism or an arbitration committee selected by himself and the Blue Cross and Blue Shield Plan.

- What about a complicated or unusual case with higher fee?

These cases will be considered individually and payment above the usual and customary fee can be provided.

- Will fees of physicians who choose not to volunteer for this program be paid a lesser rate?

No. The allowances are the same for all physicians fees with the payments made directly to the volunteering physicians, and to the Subscriber if the physician chooses not to volunteer.



ge to all physicians m Shield of Nebraska

Will specialist fees be mixed in with others who have less training and experience?

Specialists' fees are kept separately. The definition states: "Customary is defined as that range of usual fees charged by Physicians of similar training and experience for the same service within a given specific limited geographic or socioeconomic area." In addition, the fees of specialists are classified into two areas: (1) Omaha and Lincoln, and (2) the rest of the state. This methodology is designed to reflect any variance of fees by specialty and socioeconomic area. If the fees for a given service vary by specialty and area, the Usual and Customary allowances will likewise vary. Conversely, if the fees are similar, so will the allowances be similar. (Some fees are higher in category (2) than in (1) in certain cases.)

Why does your Company think it has a right to set physician's fee?

We don't set fees. Only the physicians do this. From these fees, we determine the Usual and Customary allowances.

Will physicians have the same problems with Welfare, the Veterans Administration, Medicare and other insurance companies who arbitrarily set Usual and Customary allowances below physician's fees?

We administer Usual and Customary differently than other thirdparty payors. Our method calls for using only actual fee data of Nebraska physicians, updating profiles annually, and paying on the 90th percentile basis. Also, if a physician's fees on a given case are above the Usual and Customary allowance, we advise him of this in advance of payment being made so if there were complications or other unusual circumstances, he can let us know so individual consideration can be given to the case. This can avoid problems with patients who aren't even aware of this situation since this correspondence with the physician is exchanged before payment is made and notice of such payment is given to the patient.

What about physicians who just started practicing a short time ago and whose expenses are higher than older physicians. As a result, newer physicians would have higher fees. Will new physicians' fees be mixed in with older physicians and thus get paid less?

Our method calls for paying on the 90th percentile basis. To say it another way, if only 10% of the physicians in the area charge higher fees than the older physicians, their fees will still be paid.

The contract says physicians have to accept your payment as a full payment, but many of your contracts only pay 80%. Why should physicians discount their fees 20% for your members?

The 20% coinsurance is the responsibility of the patient to the physician. Likewise the deductible, if any.

What about collecting Reasonable fees in full when they aren't entirely covered by your program?

The coinsurance or deductible, if any, as well as services not covered under the contract, are the patient's responsibility. Also, the contract provides that if arrangements are made with the patient on the specific fee prior to the covered services being performed, the patient is then responsible for any agreed upon fee over the Usual and Customary allowance.

In addition, on any disagreements, the physician can use the NMA's peer review mechanism or an arbitration committee, whichever he or she chooses, to resolve the issue.

e Cross
e Shield

braska

WashingtonNotes

Cost containment.

The Congress recessed for the Fourth of July holiday without the House Commerce Committee taking final action on the Administration's proposed hospital cost containment legislation. May and June have seen a bitter struggle within the seesawing committee, marked with a number of recriminations, including one that the White House had agreed to back a new \$75 million Veterans Administration hospital in Camden, N.J., after Rep. James Florio (D-N.J.) decided to back the cost containment bill.

The two month struggle has pitted the Carter Administration's attempt to place an artificial cap on hospital revenues — an imposition of controls on just one part of the economy — against a voluntary effort group (VE) composed of the AMA, the American Hospital Association, and the Federation of American Hospitals.

The AMA has supported the overall goals of the wide-ranging disease prevention-health promotion bill introduced by Sen. Edward Kennedy (D-Mass.).

The bill provides a new program of federal formula grants to states to assist them in meeting the costs of planning and providing health services. These state programs would be directed at reducing the five leading causes of mortality within the state through systems of early detection, screening and prevention of these conditions. A state could also receive formula funds for programs designed to reduce the five leading causes of morbidity within the state.

Special project grants would also be available for: (1) treatment of hypertension; (2) immunization of children; (3) community fluoridation programs; (4) prevention of illnesses caused by environmental factors; (5) prevention of rodent-borne diseases; (6) physical fitness activities; and (7) lead-based paint poisoning prevention.

AMA and Bakke.

Immediately following the Supreme Court decision in the Bakke case, C. H. William Ruhe, M.D., AMA Senior Vice-President, made these comments on behalf of the Association:

The Supreme Court ruling seems to permit medical schools to continue using race as one factor in determining admission criteria. We hope that medical schools will, therefore, continue to use those selective admissions programs designed to increase the number of minority students. It is only through these types of programs that we can hope to increase the numbers of minorities in the practice of medicine.

The AMA has long been in support of programs designed to increase minority representation in medical schools and in the practice of medicine. This position was reaffirmed last week in St. Louis at the Association's Annual Meeting through acceptance of a manpower report of the AMA Council on Medical Education. The report addresses the issue of "Black and Other Minority Group Physicians" with the opening statement: "The inadequate representation of minority groups in the medical profession and in medical school enrollments remains of concern to the AMA."

Laboratories.

The House Ways and Means Health Subcommittee has approved the Clinical Laboratory Improvement Act.

The new provision would prohibit percentage contracts with hospital-based physicians unless the charges were reasonable in terms of what the hospital would have paid for such services if the physician had been employed by the hospital, and the cost of other reasonable expenses incurred by physicians in performing the services. This provision would be applicable to clinical laboratories outside of a hospital.

The Health Subcommittee also approved language which provides that "if the Joint Commission on Accreditation of Hospitals imposes standards for hospital laboratories that are at least equivalent to the national standards, the Secretary of HEW (or the state, in the case of a state with primary enforcement responsibility) could deem a laboratory in a JCAH-accredited hospital to be in compliance with the national lab standards."

Federal money.

The House approved a \$55 billion money bill for the Health, Education, and Welfare Department, both more and less than the Administration requested. The confusion arose because the House added \$641 million to specific programs, but also voted a \$1 billion general chop that may prove meaningless. Another \$17 billion of HEW programs must go through the appropriations mill, since the House is deferring action on these programs until their extended authorizations are approved later this year.

An amendment denying federal funds for Medicaid abortion payments unless the mother's life is imperilled was adopted by the House ensuring still another controversial go-around with the Senate on the emotional issue.

The bill is now in the Senate awaiting action.

The rather muddled budget situation saw HEW Secretary Joseph Califano writing letters to lawmakers deploring cuts on the one hand and threatening a Presidential veto for too fat a bill on the other.

The \$1 billion "out" in effect was a challenge to Califano's report earlier this year charging that fraud, waste, and abuse is costing the Department more than \$6 billion a year.

Much of the increase over the Carter budget voted by the House was for health manpower and general education outlays, which the Administration wanted trimmed. The National Institutes of Health received \$305.7 million more than the budget figure.

Many of the health program appropriations were sought by the AMA which had urged that key programs, especially in the health manpower and national health service corps areas, not be slashed.

The Hebert Naval Medical Center: please read this.

The F. Edward Hebert Naval Regional Medical Center in New Orleans is a \$22 million white elephant that should be abandoned by the Navy, reports the General Accounting Office. The Defense Department agrees with the findings.

The GAO, Congress' investigative agency, said the westbank installation has a daily average patient load of 23, less than 10 percent of the 250-bed capacity. The potential for increasing the work load significantly is virtually nonexistent, said GAO.

Annual operating and payroll costs for the hospital amount to more than \$7 million. GAO suggested the facility be used by the state of Louisiana for a planned adolescent mental health care installation, or that it be leased to Westbank Medical Center, Limited, which operates a nearby for-profit hospital.

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For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days



Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms

Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI

Low incidence of bacterial resistance in community practice

■ Convenient *b.i.d.* dosage provides day-and-night antibacterial control

■ Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended at initial episodes of uncomplicated urinary tract infections treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (Federal Register, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of susceptibility to trimethoprim-sulfamethoxazole indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, prothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, colitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarthritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).



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the Bactrim™

3-system counterattack



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Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of

Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has no significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

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- Benzoyl peroxide in a special alcohol gel base—Reliable and predictable, imparts a pleasant cooling sensation with controlled drying of sebaceous oils. Accelerates desquamation.
- "BP base/bond" for uniform therapeutic deposition of benzoyl peroxide—Reduces burning sensation on application, for greater patient acceptance.
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Past and Present Hazards of Working With Infectious Agents — R. M. Pike (Univ of Texas Health Science Center, Dallas, TX 75235) Arch Pathol Lab Med 102:333-336 (July) 1978.

Over 4,000 cases of laboratory-associated infection have been recorded. Some of the agents involved often in the past are less frequently the cause of such infection in recent years, and some agents are more likely to infect those working with them than others. Pipetting, the use of a needle and syringe, and spills were most frequently involved in accidents resulting in infection, but in the majority of cases no recognized accident occurred. In these instances, infectious aerosols, produced in various ways, are probably the most frequent causes of laboratory-associated infection. The introduction of protective devices and emphasis on safe procedures seem to be reducing the risk of accidental infection. Although work with tumor viruses and recombinant DNA research may not be as hazardous as was originally feared, continued caution is advised.

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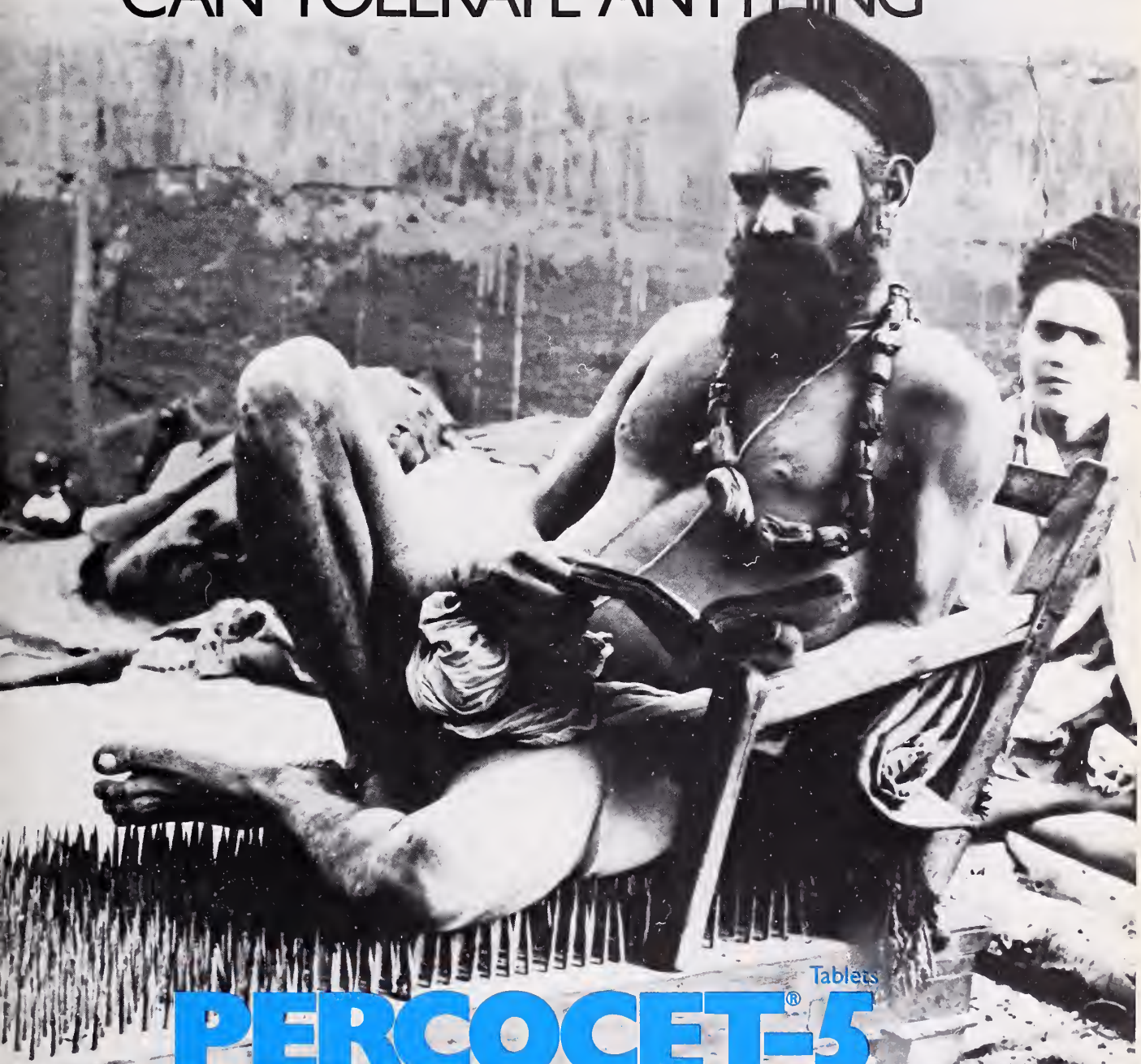
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Hypertension Treated by Salt Restriction —

T. Morgan et al (Royal Newcastle Hosp, New South Wales, Australia) *Lancet* 1:227-230 (Feb 4) 1978.

Thirty-one patients with a diastolic blood pressure between 95 and 109 mm Hg were treated for two years with a diet involving a moderate restriction of salt. The results are compared with those in a control group and in a drug-treated group. Salt restriction reduced the diastolic blood pressure by 7.3 ± 1.6 mm Hg, a result similar to that in patients treated with antihypertensive drugs. In the untreated group the diastolic blood pressure rose by 1.8 ± 1.1 mm Hg. Most patients did not achieve the desired amount of salt restriction and a stricter adherence to the diet might have caused further falls in blood pressure. Excessive salt intake is probably a major cause of the epidemic of hypertension in "civilized" countries. In persons with a diastolic blood pressure between 90 and 105 mm Hg, salt restriction should be tried before drugs.

Effects of Caffeine on Plasma Renin Activity, Catecholamines and Blood Pressure — D.

Robertson et al (Medical Service, Johns Hopkins Hosp, Baltimore, MD 21205) *New Eng J Med* 298:181-186 (Jan 26) 1978.

Using a double-blind, randomized, cross-over protocol, the authors studied the effect of a single dose of oral caffeine on plasma renin activity, catecholamines, and cardiovascular control in nine healthy, young, non-coffee drinkers maintained in sodium balance throughout the study period. Caffeine (250 mg) or placebo was administered in a methylxanthine-free beverage to overnight-fasted supine subjects who had had no coffee, tea, or cola in the previous three weeks. Caffeine increased plasma renin activity by 57% and plasma epinephrine by 207%. Urinary normetanephrine and metanephrine were increased 52% and 100% respectively. Mean blood pressure rose 14/10 mm Hg one hour after caffeine ingestion. There was a slight fall and then a rise in heart rate. Plasma caffeine levels were usually maximal one hour after ingestion but there was considerable interindividual variation. A 20% increase in respiratory rate correlated well with plasma caffeine levels.

Brief Summary of Prescribing Information Combined TEGOPEN® (cloxacillin sodium) Capsules and Oral Solution

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Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

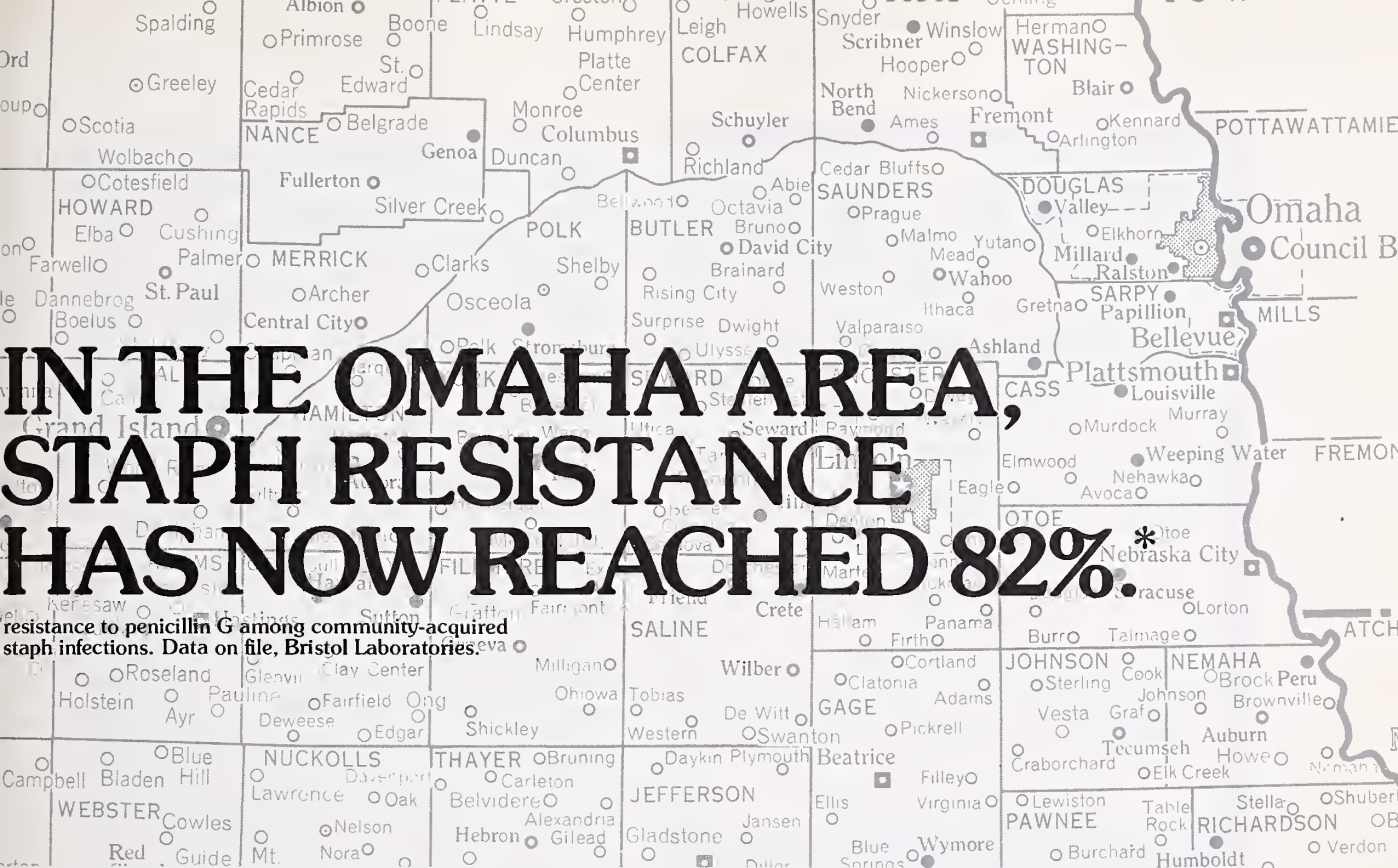
Usual Dosage: Adults: 250 mg. q. 6h.

Children: 50 mg./Kg./day in equally divided doses q. 6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

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Serum Myelin Basic Protein Assay in Diagnosis and Prognosis of Patients With Head Injury — D. G. T. Thomas et al (National Hosp, London, England) *Lancet* 1:113-115 (Jan 21) 1978.

Serum levels of myelin basic protein (MBP), a nervous system specific protein, were measured in 157 patients after head injury and related both to the type of brain damage and to the clinical outcome assessed three months after injury. Mean concentrations of MBP in patients with severe intracerebral damage, with or without associated extracerebral hematoma, were substantially raised at the time of admission and remained high for two weeks after injury. In patients with extracerebral hematoma not associated with severe intracerebral damage, mean MBP values rose four to six days after injury and were substantially raised only in patients with a poor outcome. Mean serum MBP concentrations in patients with a good outcome after injury were similar to those in controls. In patients with a poor outcome the mean MBP levels between two and six days after injury were significantly higher than in those with a good outcome.

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Lung Cancer Risk Among Beauticians and Other Female Workers — H. R. Menck et al (Dept of Pathology, Univ of Southern California School of Medicine, Los Angeles, CA 90033) *J Natl Cancer Inst* 59:1423-1425 (Nov) 1977.

Lung cancer risk among occupational groups of women was reviewed. A previous suggestion of a sixfold risk of developing lung cancer among beauticians was not confirmed; however, an approximately twofold risk was found.

Significance of Chest Pain During Treadmill Exercise: Correlation With Coronary Events — J. P. Cole (Memorial Hosp Medical Center, Long Beach, CA 90801) and M. H. Ellstad, *Am J Cardiol* 41:227-232 (Feb) 1978.

A follow-up study of 1,402 patients with a positive maximal treadmill stress test was made to evaluate the significance of angina during the test. Life tables were constructed and evaluated to significance of age, sex, and work load at onset of angina. Coronary events (myocardial infarction, progression of angina, and coronary death) were twice as frequent in subjects with angina and S-T segment depression as in those without angina. The increased incidence in four years held for all coronary events and was still doubled at seven years for progression of angina and coronary death. The incidence of coronary events was more than twice as great when the angina was induced by a light work load (4 metabolic equivalents [METS]) as when it was induced by a heavy work load (8 to 9 METS). Men aged 41 to 50 years having angina during exercise testing had a threefold greater incidence of coronary events and a fourfold greater incidence of myocardial infarction compared with their counterparts who had S-T segment depression alone. Angina during exercise testing identified 85% of true positive tests for coronary artery disease, whereas S-T depression alone identified only 64% of such tests. Angina during exercise testing increases the sensitivity of the test and identifies cohorts of subjects at high risk for subsequent coronary events.

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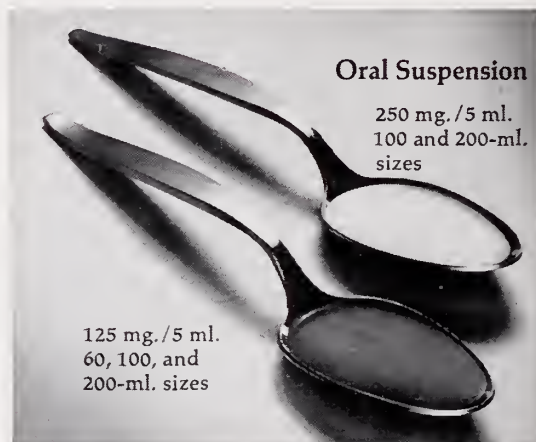
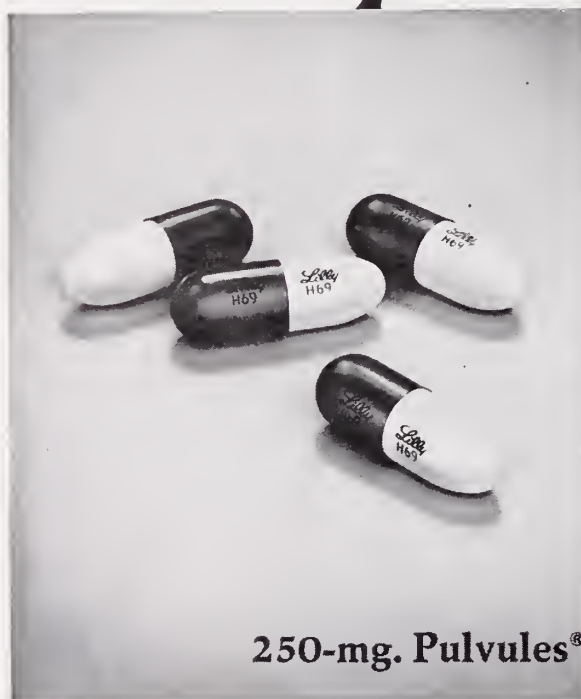
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CAN YOU SUE YOUR TAILOR FOR MALPRACTICE?

I bought a suit six months ago and the stitches are coming out, and I wonder if I should sue the tailor. I took home some milk and it was spoiled the next day, and my bill at the grocery was about as much as the grocer once took in in a whole day, but I forgot to sue him for malpractice. My car stalled, and they worked on it and I paid them and it stalled again; I wonder if they carry malpractice insurance.

Suing is a way of life now, but why sue the doctor? Sue the so-and-so, I read in what was laughingly called a book; he botched up the operation, and he should be made to pay you. But if you have chosen your doctor and have accepted his judgment, and things do not go well, the idea of his having to pay you money is abhorrent; it is illogical and discriminatory and devoid of legal meaning and of justification.

I took my slacks to the cleaner and it came back smaller; I did not sue him for malpractice. My dishwasher stopped washing dishes, and when they had fixed it, it stopped washing dishes again, but I did not sue them for malpractice.

A house-helper broke the top of my kitchen range; I did not sue for malpractice. I sent a birthday-telegram and it was delivered to the birthday-lady's daughter. It caused me severe anguish and an emotional upheaval, but I forgot to sue the telegram company for malpractice.

If these injuries seem slighter than ours, it is not an adequate defense for singling us out. Sue the tailor and the mechanic for less, but if you are going to sue me when things do not please you, sue everybody. Otherwise, don't sue me. I don't like suing the doctor, anyway.

—F.C.

THE TEST-TUBE BABY, OR THE COLE PROCEDURE

As I understand it, the lady's tubes were blocked, so they removed some of her ova

and cultured them in a nutrient broth in a laboratory dish, and then they added her husband's semen, and fertilization took place; and at an appropriate time, and after suppressing menstruation, they transferred the embryo to the woman's uterus, where it lodged and stayed, until the fetus came to term and she was delivered.

But they had several other techniques at their disposal, it seems to me, simpler ones, and others not quite as easy.

1. They could have bypassed the obstruction and performed tube-to-tube anastomosis around the blockage.

2. They might have gone around the occlusion and sewn the oviduct (proximal to the stoppage) to the uterus.

3. The fetus could theoretically have been kept in a nourishing solution, in a bathtub-size container, until it was ready to come into the outside world.

4. The ova might have been transplanted to the uterus.

5. They might have bypassed the obstruction with a segment of vein.

6. Or a small piece of safety-proven artificial tubing, plastic probably, could have been used to get around the block.

I like number one best, and the others about as well, except, of course, for the bathtub uterus. All but that one avoid the test-tube idea with its drama and its objections, based on the feeling that a laboratory dish is no fit substitute for a uterus.

I am not an obstetrician, but I can think.

—F.C.

MARIJUANA FOR OUR PATIENTS

Marijuana appears to have medical uses; it is reported to be good for glaucoma and for the nausea and vomiting associated with chemotherapy for cancer. But of what use are these reports? If you have glaucoma or cancer and you need marijuana, what can you do? You must find a seller, do business

with a criminal and fall into his hands, you must buy an impure product and pay a high price. And you will have broken the law and you may be arrested.

If you know that morphine is good for pain, that antibiotics are helpful in infection, and that digitalis is useful in treating heart disease, you have only to prescribe or obtain these things at the drug store, But what of the patient with glaucoma or cancer? We do not give heroin in this country, but there are other things and they are sufficient. For chemotherapy-nausea there is only marijuana and it is beyond our reach, and I find this situation intolerable.

A patient needs marijuana; he has read these reports; he knows that marijuana will help him; and he cannot get it. His physician admits the patient needs marijuana, and the doctor cannot prescribe it.

In two states, patients have gone to the courts and have won, so that they can somehow get the drug and use it for a legitimate purpose. But this is not the solution. Going to court applies only to an isolated instance; it means unwanted publicity; it is expensive and it wastes time. I suggest that if these reports are to continue, we make them sensible, so that a doctor may prescribe marijuana or tetrahydrocannabinol for chemotherapy-induced nausea or for glaucoma; so that a patient can go to a pharmacist and get the marijuana he needs without dealing with lawbreakers, without publicity, and without breaking the law himself. When you are sick and you need help, it is frustrating to read that marijuana will help you, but you cannot get it.

—F.C.

SAY IT ONCE

It was late in the afternoon, or maybe evening; it was so long ago, and I think we had just finished operating and I was making rounds with a very good surgeon, and he said to me, Frank, say pediatrics. So I did, and I looked at him, and he smiled and he said, you'll never say it right again.

It was some time ago, but I remember it so well. Anyway, try saying these:

stragety
pedriatics
jone and boint

You have to say them out loud, and you'll never get it right again.

—F.C.

THERE'S GOOD NEWS AND THERE'S BAD NEWS

Kings used to lop off the heads of well-meaning messengers who brought them news of lost battles. Being the bearer of unpleasant tidings is not the most desirable of duties. And when someone consults with you, and you have only unwelcome information to give, the patient may reject both you and the diagnosis. I didn't make you sick, you want to say, but the rift between you persists.

Undertakers (I dislike bringing them in here with us doctors) were similarly repulsed, since they brought death with them.

It is easy to come into the patient's room and say the tests or the operation showed that everything is fine, and you are sure to get well.

When what you have to say is not going to make the patient happy, you may take refuge in silence, you may flee to idle chit-chat and wait until you are asked, or you may blurt out the truth, and of course some will gloss over unpleasant circumstances, but not untruthfully; while there may be some who hide the truth.

We hesitate, we stammer out pretense, we soften the blow, and why not? It is our duty to take on ourselves the agony the patient carries. We resort to euphemisms. We soften our voice and our words, we speak gently, we bring sympathy with us to the sickroom. Yet while we bring news of sickness, we do not bring the sickness.

Those of us who announce the truth bluntly, without being asked, have it easy; some of us cannot do this. For there is always the reluctance to say what the listener will not want to hear, but it is a duty, and it is handed to us with our diplomas.

—F.C.

Manic Depressive Psychosis: Diagnosis and Treatment

MANIC depressive psychosis is an affective disorder of unknown etiology. According to the **Diagnostic and Statistical Manual of Mental Disorder-II**, third edition,¹ this disorder is divided into three major subtypes: manic, depressed, and circular type.

The manic type consists exclusively of manic episodes. These are characterized by excessive elation, irritability, talkativeness, flight of ideas, accelerated associations, and hyperactivity. The triad of elation, flight of ideas, and increased motor activity is observed in almost every manic person. This is in contrast to certain other types of disorders, particularly schizophrenia, wherein the patient may display a manic picture, but not the interlocking influence of emotions on the intellect with the motor behavior aberrations.² There are three forms of mania: (1) hypomania, (2) acute mania, and (3) delirious mania. These three types of mania basically differ from each other quantitatively but not qualitatively.

The unipolar depressed type of mania consists exclusively of depressed episodes, which are expressed by the basic symptom triad of a severely depressed mood, mental hypoactivity, and motor retardation. This condition may progress to a stuporous state.

Illusions, hallucinations, and delusions may occur with both manic and depressed types, and are attributable to, and in conformity with, the dominant mood. In the manic patient, delusions of grandeur are frequent. In the depressed type, delusions are usually those of guilt or of a somatic nature. Hallucinations are rare and, when occurring, usually fleeting in nature and not elaborate in content.

The circular (bipolar) type is distinguished by a history of at least one attack of both a depressive and a manic episode. There is no difficulty in establishing the diagnosis of acute mania or acute depression. However, with many patients, the diagnosis of manic-

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depressive illness may not be easily made. Therefore, it is incumbent upon the physician to make a careful investigation in which family history, developmental experiences, premorbid personality structure and the onset and the development of the illness, including all behavioral and physical symptoms, are thoroughly reviewed.³ As an example, a manic phase of manic depressive illness can usually be distinguished from catatonic excitement because the manic patient is usually older, has had a history of mood swings, and has taken weeks or months, rather than days, to develop the behavioral symptoms. Episodes of manic behavior seen in the course of acute and chronic brain syndromes, e.g., thyrotoxicosis, tumors, general paresis, can be distinguished from the manic phase of bipolar disease by the absence of previous manic episodes and the presence of organic findings.⁴ On the other hand, schizophrenia may present with prominent affective disturbances, when the final diagnosis is schizophrenia, schizoaffective type. Whether this reflects a mixture of schizophrenia and manic disease, or is a distinct disease entity, remains to be seen. The differentiation between schizophrenia and manic depressive illness may remain difficult until after the illness has run a course of several years. When depression presents as the primary symptom, one would also have to consider involutional melancholia, and psychotic and neurotic depressive reactions in the differential diagnosis. Involutional melancholia develops during the involutional period, usually defined as after age 45, and there is no history of mood swings. The patients usually describe themselves as compulsive, and instead of displaying psychomotor retardation, tend to be

anxious, apprehensive, and agitated. In both the psychotic and neurotic depressive reactions, an important distinguishing feature is that these illnesses seem to follow a clear-cut precipitating event.

In the treatment of manic depressive illness, severely ill patients must be treated in a hospital setting; selected patients can be treated as outpatients. The manic episode of manic depressive illness may be treated with neuroleptic drugs, electroconvulsive therapy, lithium, or a combination of these agents or regimens. During the past 20 years, lithium treatment has become the treatment of choice for the manic phase of manic depressive illness. An acutely ill manic patient may receive therapeutic lithium treatment in one of three modes, depending upon the patient's condition and the physician's preference. Since the lithium effect usually comes about slowly, that is between two and seven days, one method is to control the patient's behavior during this lag period with one of the neuroleptics, such as chlorpromazine or haloperidol. The rapid effect of the neuroleptic drugs insures that the patient receives adequate sleep, and, most importantly, before lithium is started, the taking of adequate fluids and salts.⁶ If a patient is extremely manic or suicidal, ECT is indicated and should be used first. After the initial treatment with neuroleptics and/or ECT, prescription of lithium is specific for the treatment and prevention of further relapses.⁷

The simultaneous administration of a neuroleptic drug and lithium is another treatment approach. When the patient is controlled on both drugs, the neuroleptic should then be withdrawn. Some physicians also prefer to treat the acute phase of mania solely with lithium. Besides lithium's direct therapeutic application in the acute manic patient, lithium also exerts a prophylactic effect on patients with recurring mania, those with manias and depressions, and those with recurrent endogenous depressions.

Lithium is available in a number of different salts, but the one most commonly used for treatment is lithium carbonate, which can be taken orally. If lithium is to be

used in combination with neuroleptics, a moderate dose of lithium should be given initially, i.e., about 900 to 1800 mg per day divided into three or four doses. Serum should be drawn and lithium levels determined about three times a week during the first week, and, if necessary, the dosage should be adjusted to keep serum levels in the 1.0 to 1.3 mEq/L range. This is important as lithium is potentially a dangerous drug with quite narrow therapeutic and toxic ranges in comparison with other drugs. As the acute mania subsides, many patients show a sharp rise of serum level, and a decrease in dosage may be required. Serum levels should be taken once a week for the next three or four weeks after the psychotic episode has ended and the neuroleptic drug has been withdrawn. Once the serum level has been stabilized, the patient should have lithium levels checked at least once a month. It is important that blood samples be obtained to determine the serum concentration so as to give guidance to the patient and physician about dosage. For example, lithium levels should be taken prior to ten hours after the last dose of lithium has been taken. This usually occurs early in the morning of the next day before the morning dose is given.⁸ For the average patient, maintenance blood levels are in the order of 0.8 to 1.3 mEq/L. Whether lithium is used therapeutically or prophylactically, it should not be allowed to exceed 2.0 mEq/L.⁸ Once proper dosage has been established and no troublesome adverse effects have emerged, blood lithium levels can be assayed less frequently.

There are over 30 mild somatic side effects that may be encountered early during lithium therapy.⁹ Side effects most commonly seen include lethargy, transient nausea, diarrhea, abdominal discomfort, frequent urination and a fine tremor of the hands. The nausea and abdominal discomfort may especially be distressing to the patient and may result in not taking lithium during the early phase of treatment. The patient should be informed of the possibility that these side effects are to be expected and that the discomfort will usually disappear in a few days. The principal characteristic of a severe lithium toxicity is its devastating effect on

the central nervous system. Impaired consciousness is invariably present, and coma may develop. Since a complete description of side effects of lithium is beyond the scope of this paper, one should consult a textbook for further information.^{3, 4, 9, 10}

Before starting a patient on lithium maintenance, one should obtain baseline T₃ and T₄ levels, as lithium has an antithyroid effect, and in a small percentage of cases will lead to depression of thyroid function and goiter formation. The early stage of hypothyroidism may produce depressive symptoms which could easily be mistaken for a recurrence of a depressive episode of manic depressive illness and result in improper treatment. Since lithium is excreted by the kidneys, an assessment of renal lithium clearance is essential before starting this

drug. A patient receiving maintenance lithium should be advised to take lithium as prescribed in divided doses; to inform the physician of any change in diet, salt restrictions, or diuretics that another physician may have ordered; to avoid excessive sweating; and of side effects that may be expected to occur with this drug.

There is some evidence to show that lithium has an antidepressant effect. It is however, not the treatment of choice with already existing depressive illness. The moderate to severe depressive episodes are best managed with either antidepressants or ECT.

References may be obtained from the author.

Diagnosing Torsion of the Testicle in the Nuclear Medicine Department

INTRODUCTION

WHEN a patient presents with testicular pain it is sometimes difficult to differentiate between testicular torsion and epididymitis. We have recently had two patients in whom the diagnosis of testicular torsion was made in the nuclear medicine department by doing a simple, rapid and safe examination which we call testicular perfusion examinations.

METHODS

The patients were placed under a Searle Radiographics model HP Anger camera using a 140 KEV parallel hole collimator. The patient's legs were placed together, and the penis taped to the abdomen. The leaded cape used for shielding while obtaining vertex views of the brain was positioned to shield radiation coming from the rest of the body leaving only the scrotum exposed to the collimator.

Ten millicuries of technetium 99m as pertechnetate was then injected I.V. and

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5-second serial images were obtained immediately following the injection. A 300,000 count image was then obtained to delineate the perfusion of the pertechnetate into the body tissues. The entire procedure took less than 5 minutes with each patient.

DISCUSSION

The first patient was a 17-year-old white male admitted through the emergency room with the chief complaint of abdominal pain, nausea, vomiting, and swelling of the left testicle. There was a 2 to 3 cm mass in the epididymal area of the left testicle which was tender and possibly fluctuant.



Figure 1

It was at first thought that this represented a bacterial infection of the left epididymis, and treatment was instituted using antibiotics. However, there was no response to this treatment, and therefore on the sixth hospital day, a testicular perfusion examination was performed showing no blood perfusion to the left testicle as manifested by an oval cold area representing the non-perfused left testicle. (see figure 1)

He was then taken to the operating room, where he underwent a derotation of the left testicle with fixation. Postoperatively he did remarkably well, and he was discharged in satisfactory condition on the fifth postoperative day.

The second patient was a 42-year-old white male admitted with severe right testicular, right lower quadrant, suprapubic, and low back pains. The right testicle was firm, slightly enlarged, and exquisitely tender. On the day of admission, a testicular perfusion examination was performed showing no perfusion to the right testicle, again manifested by an oval cold area within the scrotum. (see figure 2) The patient was taken to the operating room where an infarcted right testicle was found and removed. He was dismissed from the hospital on the second postoperative day in satisfactory condition.



Figure 2

RESULTS

Most patients having acute testicular torsion probably represent no significant diagnostic problem, and should undergo immediate surgical exploration. Sometimes, however, the distinction between testicular torsion and epididymitis is difficult to make, especially if the urologist is called upon to make the differential diagnosis several days or weeks following the onset of symptoms.

In reviewing the literature,^{1,3} the results to date have shown that performing testicular perfusion examinations will show the involved testicle to be cold, containing no radioactivity.

Patients with epididymitis have increased perfusion to the testicle and show normal to increased radioactivity in the testicle. Patients with tumors usually show normal radioactivity although it would be conceivable to have the occasional tumor be necrotic and be cold on this exam.

It is also reported that long-standing epididymitis can be associated with an infarcted testicle and therefore on rare occasions, a testicle involved with long-standing epididymitis might appear cold.

Reducing the Stress of Practice

MOST psychiatric disorders are treated by nonpsychiatrists. The ability of many of these patients to provoke strong feelings can add to the stress of medical practice. Help in reducing stress from the interaction with patients can come from utilizing a simplified diagnostic approach to the problem patient. The dependent, overly-demanding type of person reaches out quickly and impulsively, putting himself in the hands of the doctor with a naive, or demanding expectation of limitless care. The physician can decide to what extent it is possible to help the patient by attempting to satisfy his needs for special attention and setting limits without impatience if they are excessive.

A second type of patient is the orderly, controlled self-disciplined type of person. When under stress he must rely upon having as much knowledge as possible about his situation. This type of patient responds well to the precise and systematic efforts that characterize the doctor's laboratory studies and treatment. He needs to be informed methodically and in sufficient detail about his illness to establish intellectual control over his anxieties.

A third type of patient is the dramatizing, emotionally involved, captivating, personal type of person. Illness is used to secure attention and sympathy from the environment. While not being too reserved, the physician should always be cautiously aware of the patient's readiness for emotional involvement. Reassurance and permitting ventilation of fears is helpful.

The fourth personality type is that of the long-suffering, self-sacrificing patient who may be seen to precipitate his own misfortunes. This type of person is paradoxically better able to cooperate in a medical regimen out of readiness to add to the "burden" that he must carry, than for the personal relief that health would bring him.

The fifth type of patient is a guarded, querulous type of person who is inclined to be suspicious of others' intentions and/or

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blameful of their motives. Illness causes him to feel vulnerable. It is essential in managing such a patient to let him know the strategy of diagnosis and treatment to reduce his suspicions without argument.

Still another type of person presents with the feeling of superiority, very powerful and all-important, or an artificial covering attitude of patronizing humility. The patient may be prone to vie with the physician and try to outdo him. It may be that the doctor can impart a feeling of security if he acknowledges the achievements of the patient, but without belittling the physician's own expert knowledge and skill.

The final patient type gives the impression of remoteness, reserve and lack of involvement with everyday events and concerns whose illness may represent intrusion into this system threatening to upset his equilibrium. Unsociability must be understood and accepted. This may be achieved by trying to maintain a considerate interest in him, quietly and reassuringly, without requesting reciprocal effort on his part.

The physician will refer patients requiring more time or specialized techniques. If he is familiar with the specific skills of various psychiatrists in his area, his referrals can result in more satisfied patients whose general medical management is thus enhanced. This can be a concern as there are currently over thirty medical psychotherapies.

Supportive forms of psychotherapy are most helpful in those patients who have undergone a breakdown of their usual mechanisms of coping with life and need help in reconstituting them. Insight producing forms of psychotherapy are indicated where the patient has attempted to cope with his usual personality mechanisms and finds them

becoming increasingly unsuccessful. Symptom removal or control by biofeedback, hypnosis, or behavior modification is indicated in those patients who developed symptoms or habit patterns in response to past stress, but are having persistence of the symptoms in the absence of current external causes of internal conflicts. Finally, in those patients who are existing in a stressful situation with a foreseeable relief of stress in the near future, medications may suffice with minimal psychotherapy.

In summary, the personalities of patients in a general medical setting can produce significant stresses to the physician and reduce his own enjoyment of life. A simplified diagnostic approach to those patients can enable the physician to manage them with greater ease and less personal distress. For those patients with emotional disorders requiring referral, the matching of the patient to the skills of the individual psychiatrist results in greater patient cooperation with the referring physician.

The Second Opinion at its Best

MUCH attention has recently been focused on the "second surgical opinion," both in the lay press and in professional publications. Unfortunately, a great deal of emphasis has been laid on "avoiding unnecessary surgery," that is, cost containment, with much less emphasis given to optimizing patient care.

The cardiac disposition conference has been described as "the only conference in the world where internists try to talk surgeons into operating." It is a prime example of a team effort to optimize patient care, and also serves as an excellent teaching forum. It is, I believe, the ultimate in "second opinion."

The basic principle is open forum. All patients for whom elective cardiac surgery is being considered are presented. Anyone may request that a particular patient be presented at conference. Most patients are brought by the cardiologists, but surgeons, residents, or medical students have also brought patients to conference if they thought care could be improved. The conference is open to any member of the medical community. Routinely invited are cardiologists, cardiac surgeons, radiologists, anesthesiologists, pathologists, referring physicians, residents, medical students, nurses, and nursing students. Most attend regularly. Because of the patient volume, we meet twice weekly, once for pediatric patients, and once for adult patients; but this is mostly to

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keep conferences to a reasonable length. We try to accommodate the referring physician in timing the presentation of a particular patient if the referring physician wishes to attend.

The case is presented in summary form by a physician responsible for that patient's care. Anyone present may add or amend as they feel appropriate. Presentations and discussions of x-rays, electrocardiograms, scans, catheterization data, and angiograms then follow. Relevant discussions occur throughout these presentations. In the interest of time, discussions are generally limited to the case presented, that is, we do not endeavor to teach students to read cardiograms in this conference.

A proposal, or a discussion of alternatives for management of the patient is next in order. This usually means one of the following: surgical management, medical management, no therapy needed, or further study

needed, such as treadmill, recatheterization for specific data, etc. When there is agreement as to what should be done, consideration is given to when. At the conclusion of the presentation, a letter is dictated summarizing the findings, who was present, and the recommendation of the conference. One copy of this letter goes in the patient's chart for later reference, and another copy goes to the referring physician. The decision is then

presented to the patient and/or parents after conference.

This format is intended to allow free input from anyone who feels they can help the patient, and to give the patient the optimal care which we believe can best come from a team approach. The educational value for all physicians present is large. We think this is "second opinion" at its best — working for the patient.

Lead Intoxication in a Child with Chronic Constipation

LEAD intoxication is of great concern in the pediatric age group, especially in children with pica having access to environmental lead sources. In this country there are about 400,000 children with elevated blood lead levels and lead poisoning is responsible for approximately 150-200 deaths per year.¹ Because the initial signs and symptoms of elevated blood lead levels may be non-specific, the diagnosis is easily missed.

CASE PRESENTATION

H.F. is a 26 month old black male referred to UNMC from a local clinic for constipation of six months duration. He had not had a bowel movement for the past two and one-half weeks. Previous stools were described as being very large, firm and crumbly, and light brown.

The child's diet was noted to be substandard, with frequent snacks of potato chips and soda pop but relatively few servings of fruits and vegetables. The mother had not noted whether voluntary retention of feces had occurred. A history of pica for many substances was also obtained. There was no history of diarrhea, melena, or hypothyroidism.

Past medical history included a right pneumonia at six months and several visits to local emergency rooms for minor head injuries. He had also had several episodes of

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emesis and epistaxis in the past. Approximately one year prior to admission the patient was seen in a local emergency room for an episode of abdominal colic, at which time scattered radiodensities were noted throughout the abdomen on x-ray. No treatment was started and he was dismissed with instructions to the mother to return if further cramping occurred. The birth and developmental history was unremarkable. He was the elder of two boys; the family was in a lower socioeconomic group.

Physical examination revealed a cooperative black child with blood pressure 100/70, temperature 36.8° C, pulse 120, and respirations 24. Height and weight were greater than 90th percentile for the patient's age. HEENT examination was unremarkable, without evidence of papilledema or gingival lead lines. The heart and lungs were within

normal limits. The liver was palpable under the right costal margin, and there was a large amount of firm stool palpable in the lower abdomen. Rectal examination revealed a large amount of very firm stool which gave a negative test for occult blood. The child was more clumsy and had more difficulty with his balance than expected for his age. He was also lethargic and offered no resistance to phlebotomy. The remainder of the neurological examination was unremarkable and development seemed appropriate for age.

On admission, white blood count was 9,600 with 29 polys, 1 band, 51 lymphs, 15 monos and 4 eosinophils. Hemoglobin was 9.1 grams% with an MCV of 56 (with 80 lower limit of normal for age). The red cells were microcytic and moderately hypochromic, with occasional stippling. Platelets appeared slightly increased and there were a few atypical lymphocytes. The reticulocyte count was 3.2%. Sickle cell prep was negative and G6PD levels were adequate.

Venous blood had pH 7.25, CO₂ content 20, chloride 107, sodium 138, and potassium 5.8. Serum calcium, phosphate, glucose, creatinine, BUN, total protein and albumin were within normal limits. Thyroid studies were all normal. Initial urinalysis on the day of admission had a specific gravity of 1.006 and a pH of 6.0.

Blood lead levels were 109 and 126 micrograms/dl whole blood, decreasing to 100, then 40 on chelation therapy (see below). Urinary excretion of lead increased from 200 micrograms/1 (22 hour collection) to 1050 micrograms/1 (12 hour collection while on chelation therapy. Urinary delta aminolevulinic acid was 1.0 mg in 22 hours and urinary coproporphyrins were 11.3 micrograms for the same time period (off chelation therapy).

An upper GI roentgenogram was normal. A scout film for barium enema revealed fecal impaction and numerous radiopaque flecks throughout the lower bowel suggestive of pica (Figure 1). Barium enema after cleanout of the colon was normal. Films of the long bones revealed radiodense metaphyseal bands consistent with heavy metal intoxication (Figure 2).

An EEG, both asleep and awake, was normal. Nerve conduction studies were normal for the patient's age. An EMG was consistent with a denervating process, compatible with a subclinical lead myopathy.

Decompression of the bowel was started with enemas and cathartics. Once substantial cleanout had been effected, a five day course of chelation therapy with calcium EDTA and BAL was begun. This reduced the blood lead level only to 100 micrograms/dl and a second five day course of chelation therapy was again given. Blood lead was 40 micrograms/dl at the time of discharge. The patient was started on oral d-penicillamine, 500 mg q day at home.

Blood lead levels determined on the patient's sib and mother were both less than 20 micrograms/dl. Douglas County health officials were contacted and they inspected the family's residence. Several samples of paint and other materials were taken and analyzed for lead, but no source of lead was found;



Figure 1
Plate plate of abdomen demonstrating radiopaque particles in the descending colon and rectum.

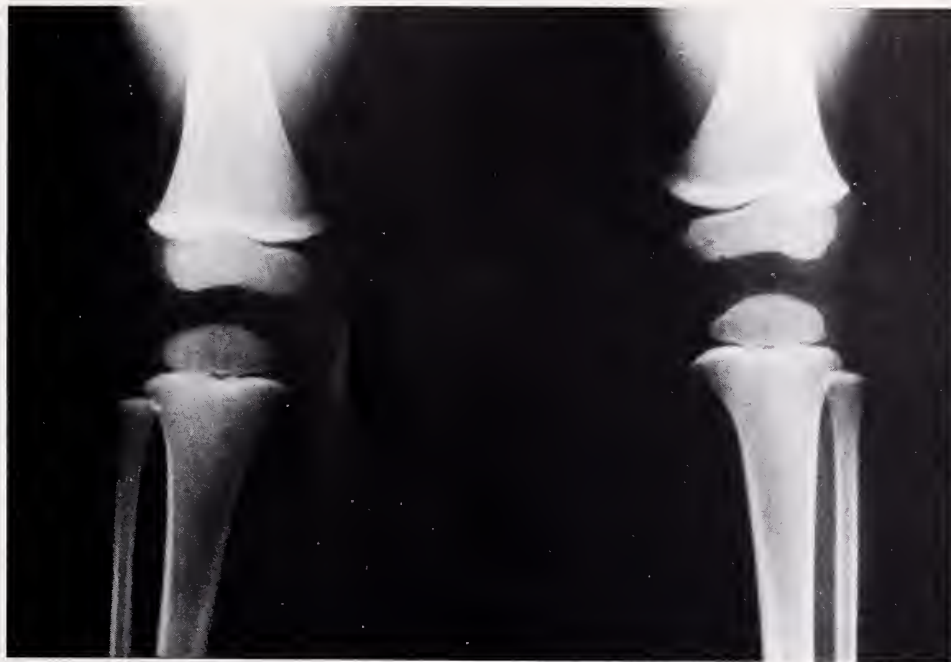


Figure 2
X-ray of both knees revealing radiodense metaphyseal bands.

however, one sample of wall paint contained 0.5 ppm cadmium, the upper limit allowed by the FDA.

Serial blood lead determinations now range between 34 and 70 micrograms/dl, the last being 40 micrograms/dl. He is no longer constipated and his anemia has now resolved, last hemoglobin being 13.3 grams% with hematocrit 39.6%. A Denver developmental examination performed at 30 months of age was normal.

According to a recent statement by the CDC, lead poisoning exists when two successive blood lead determinations are equal to or are greater than 80 micrograms/dl whole blood.² Chisolm reported that in 98 fatal cases of acute encephalopathy in Baltimore the range of blood lead was 138-750 micrograms/dl.³ The range in 46 children considered asymptomatic was 55-300 micrograms/dl. In a statement released in 1971 by the U.S. Public Health Service, it was concluded that all children with blood lead levels of 80 micrograms/dl or more should be hospitalized immediately for "the risk of acute encephalopathy in this group is great, the onset of the disease is unpredictable, and its course fulminant. If encephalopathy

develops, at least 40% of these children will sustain severe and permanent brain damage."⁴

Treatment of asymptomatic children with blood lead levels in this range includes maintenance of adequate hydration and urine flow and chelation with agents such as BAL (4 mg/Kg IM q 4 hours) and calcium EDTA (12.5 mg/Kg IM q 4 hours).⁵ It is recommended that calcium EDTA be started 4 hours after the first dose of BAL, since some of the toxic effects of lead may be intensified if the calcium EDTA is given alone in the presence of high tissue concentrations of lead. Once blood levels have been reduced to 40 micrograms/dl or less, the patient may be started on a course of oral d-penicillamine (30-40 mg/Kg/day in two divided doses), thereby avoiding the need for parenteral medications.⁶

It is difficult to state that any one factor was the sole cause of his constipation. Although it is known that patients with chronic plumbism may present with GI complaints, in children the most common presentation is that of an acute encephalopathy.⁷ In the 58 children with blood lead levels greater than 50 reported by Pueschel et al.,⁸ a history of abdominal pain was

elicited in 14, diarrhea in 11, vomiting in 11, constipation in 8 and loss of appetite in 6. (Symptoms relating to the CNS such as clumsiness and irritability were also noted in approximately one third of the 58 children.)

Whether such patients suffer any permanent sequelae of their episodes of elevated blood lead is controversial. Asymptomatic lead intoxication has been implicated in the development of mental retardation,⁹ hyperactivity,¹⁰ hypertension,¹¹ and other neurologic and psychiatric disorders.¹² In addition, several older studies have suggested that

asymptomatic lead exposure in childhood may lead to chronic renal failure as a young adult.^{13, 14}

Because lead poisoning is fairly rare in Nebraska, and because the symptoms and signs are relatively nonspecific, the diagnosis may be missed if not kept in mind. It is probable that it was missed when he presented with abdominal pain and radio-dense flecks on abdominal x-ray a year earlier.

References available from author.

Down Memory Lane

1. The mortality of Caesarean section then is higher than any other abdominal operation, except the operation for carcinoma of the stomach, which is about 10%.

2. I had a case that had a practical nurse. She said. "Do you want me to dress this cord? Do you use raisin, or nutmeg and vaseline?"

3. We learned the Nebraska law requires every teacher teaching in the schools of the state to make a physical examination of the students at the beginning of the school year.

4. The day of the Universal Specialist is gone; he never in reality existed.

5. It has appeared to those of us who are familiar with the Beet Sugar industry that there is an unusual incidence of infections in this industry, certainly more than has been observed in most manufacturing industries.

6. Are there too many nurses today? Are they charging too much for their services? Are their requirements for entering training

schools too high and correct? What suitable method if any have we to select a suitable nurse for different types of patients — say, pneumonia, or difficult feeding or ileus or mental depression cases?

7. In the olden days the problem of medical education was solved in a very simple manner. The prospective physician merely apprenticed himself to some medical celebrity and then proceeded to prosper for a variable length of time on warmed over gruel and the crumbs from the doctor's table.

8. There is no basis for believing that maternal impressions and shocks affect the fetus.

9. Our relations with the public are in direct proportion to our relations with each other.

10. Only recently has the newborn baby begun to receive its due amount of consideration.

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President's Page

The No Touching Disease

The signs are frequent clinic visits and a desire to be examined by a doctor. An unhappy and a discontented look. Lack of interest in one's appearance. A bad-tempered, angry attitude under stress. Obvious irritability. The symptoms include a feeling of loneliness and abstraction from one's friends, morbid doubts of other peoples' loyalty and feelings of insecurity. A fear of unpopularity and inhibitions of feelings. Unusual reaction to others when one is inadvertently touched. Guilt feelings of touching another person. Loss of tenderness and ability to comfort people in distress. A hesitancy and doubt when comforting people in pain. A strange, inhibited and cold attitude towards strangers and foreigners, horror at the sight of courting couples. An inability to communicate with people standing near-by in public places and churches, a tendency for nurses to spend more and more time talking to each other at the side of the ward rather than tending patients. Shyness and introversion. An exaggerated interest in the no-touch techniques of dancing.

How did it all develop? Mediterranean people readily touch each other. Monkeys spend hours a day touching each other. Human observers of course think they are removing fleas from each others' bodies rather than collecting the salt. Families in this country used to consider it quite normal for the whole family to sleep in one bed. Village peace involved community dancing with lots of touching. Soldiers and sailors slept together in close proximity.

Is our fear of sex the reason? Some people touch only during the sex act. Is Christianity to blame? Christ cured people by laying his hands on them. Is the church at fault? High pulpits and private pews? Could it be the fault of our parents and their parents? Yet mothers are constantly touching their babies at least until the child starts having a will of its own. Perhaps the children antagonize their parents by premature display of self will. Humans stroke cats, pat dogs, snuggle up to horses without apprehension yet they refuse this grace to human beings. We should



all learn to touch people we love and know every day. We should shake hands more easily and embrace each other more readily. Little children should sit on older persons' knees and teachers and parents should spank their children with their hands, instead of sending them to bed or standing them in a corner. For the more timid, touching can be done with the sound of the voice and the look on one's face. Now the family doctor is becoming infected. Group practice appointment systems; always having the receptionist answer the phone and not daring to go to the phone in case he/she becomes involved. The use of private numbers at home. Living as far away from the practice as possible. White coats, medical records, bottles of pills, a nurse to do the dressings, ear syringings, immunizations, and injections. We are dealing with an epidemic, and the normal uninfected are becoming abnormal. Don't we realize that when a patient comes to the clinic, he is frightened that the doctor will reject him. Frightened that the doctor hasn't

the time to see him. Frightened that the doctor may not understand his problem. Don't we realize that our secretary's or receptionist's voice and manner can deeply hurt and offend because every patient believes that his doctor has told his receptionist to keep him in person away from the doctor.

How did the older GPs treat this disease? They took the patient's pulse, they pulled his eyelids down to see if he was anemic. They looked into his mouth with a flashlight, they placed a stethoscope down the dress or past the shirt buttons. They held his hand and said, now tell me what's wrong with you. They opened the door for the patient to go

out, they shook his hand. They put the hand on the knee that hurt or on the belly that had the spasms. They pumped the hand of the newly fledged father and accepted his cigar. They used their ears to touch their conversation and thoughts, and a soft understanding voice to massage away their fears. They let each person know by the tone of voice or action that they are welcome — that he knows they have problems or illnesses or they would not be in the clinic. We must pick up this banner so we can honestly say that we have used our hands in treating and comforting patients.

Houtz G. Steenburg, M.D.

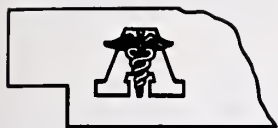
Welcome New Members

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St. Joseph Hospital
601 North 30th Street
Omaha, Nebraska 68131

Morris T. Sandeno, M.D.
2116 West Faidley
Grand Island, Nebraska 68801

REINSTATED MEMBERS NEBRASKA MEDICAL ASSOCIATION AUGUST, 1978

Frank A. Kreitler, M.D.
Box 460
106 East Second Street
Tilden, Nebraska 68781



The Auxiliary

MEANINGFUL MESSAGES . . . a means of Cost Containment

At the spring meeting of the Nebraska Interagency Health Council, Mrs. Pauline Myles of the National Health Council suggested that we need effective public health **MESSAGES**. The consumer must be made more aware of his responsibility for his own health and well being.

Obviously if we have good messages we need good **MESSENGERS** to carry on a meaningful program of health in our community. We in the Auxiliary to the Nebraska Medical Association have both.

At the Post Convention Board Meeting it was announced that this year the Auxiliary would have a Health Committee Chairman who would coordinate the existing and new programs of health. The Project Bank coordinator continues to encourage the implementation of Auxiliary projects and reports of county officers which will be submitted to the national office for inclusion in the Project Bank for use by other Auxiliaries.

The Health Gallery continues to be our Number One project state-wide. But in addition to this we will continue to be messengers in our community. Messengers of preventive medicine. Promoters of wellness.

The purpose of AMA Auxiliary has always been the promotion of good health care for the people of our nation. This will be re-emphasized this year through a national Health Projects Committee. States will be urged to emphasize that maintenance of good health is vital to quality living.

Another slant to this thought is that when we emphasize the importance of healthy living we are suggesting a means to control spiraling health costs in a voluntary manner and without governmental intervention. A person in the peak of health does not need extensive care. The message is that the modification of a lifestyle through good nutrition, exercise and giving up of harmful habits is essential to good health.

One challenge for our Auxiliary members is that of immunization. The goal of HEW is to immunize 90% of the population by 1979. This challenge is one to which we may address ourselves in every community in Nebraska. The AMA has furnished each Auxiliary with materials, and there is possibility of carrying out an effective program without the aid of the Government.

Another challenge is the possibility of each Auxiliary being the core group of the community in instruction of basic life support. Ideally each group would have its own certified instructors.

Each Auxiliary has received a "package program," prepared by AMA Auxiliary, giving information on organization of community programs in aging or Alcohol Education. Each to be considered as a possible program to emphasize.

The messages seem challenging and there is no doubt but what we have Auxiliary members who will carry them effectively into the communities of Nebraska.

Mrs. Harry D. Shaffer (Dorothy)
President, NMA Auxiliary

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Total cost of the Health Galleries Project \$500,000.00
Goal for support from Medical Community 150,000.00*
*House of Delegate action October 1976, recommended
that each physician donate \$200.00 over a three year
period.

70% of the \$150,000.00 has been raised
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listed in the Nebraska Medical Journal. All
monies raised will be used for the develop-
ment of the exhibits in the galleries.

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COMPATIBILITY



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan — compatible with coexisting diseases
- Vasodilan — compatible with concomitant therapy
- Vasodilan — compatible with your total regimen for vascular insufficiency

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

VASODILAN[®]

(ISOXSUPRINE HCl)
20-mg tablets

Mead Johnson PHARMACEUTICAL DIVISION

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This asthmatic isn't worried about his next breath...

**he's active
he's effectively
maintained on**

QUIBRON[®]

Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

- theophylline for effective around-the-clock bronchodilator therapy
- 100% free theophylline

Indications: For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema.

Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitroazanaphthal reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 µg/ml.

How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon. See package insert for complete prescribing information.

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Have You Made Your pledge to The Health Galleries?

70% of the medical community goal of \$150,000.00 to the Health Galleries has been raised!! Use the form below! **SEND YOUR PLEDGE TODAY!** (All donors from the medical community are listed in the monthly issues of the **Nebraska Medical Journal**.)



In accordance with the House of Delegates action* we give/pledge \$_____ for the development and maintenance of the Health Galleries.

Make your check payable to: The University of Nebraska Foundation

Mail to: NU Foundation, P.O. Box 30186, Lincoln, NE 68588

Name: _____

Address: _____

County Medical Society _____

For my pledge please send reminders _____ Annually _____ Semi-annually _____ Quarterly

★ October, 1976 Resolution for gift from each physician for \$200 to support the Health Galleries.

Our Medical Schools

A study of 98 farmers and commercial pesticide applicators in seven Nebraska counties and a University of Nebraska research facility has revealed that almost one third had a significant level of contamination from insecticides, although not enough to cause serious health consequences.

The study, which was conceived and funded by the Institute of Agriculture and Natural Resources Cooperative Extension Service and designed and directed by the University of Nebraska College of Pharmacy, found that 30 percent of the volunteers surveyed at the Mead Field Laboratory and in the counties of Buffalo, Hall, Hamilton, Madison, Saline, Stanton, and Wayne exhibited significant contamination from spraying crops this spring with carbamate and organophosphate insecticides. The other 70 percent had little or no contamination.

Developed during World War II for chemical warfare, organophosphate and carbamate insecticides are used extensively by Nebraska farmers, many of whom have undergone the service's training program.

Although organophosphates and carbamates present less of an ecological danger than other types of insecticides, they are a greater health risk to man in causing gastrointestinal and respiratory disorders and reducing the level of a blood enzyme, called acetylcholinesterase, which is necessary for the proper function of the nervous system.

For some of the seven commercial pesticide applicators in the study who suffered a higher degree of contamination than the

farmers (although their low number and greater exposure to insecticides compared with farmers prevented any conclusive evidence to be drawn from the group), federal guidelines make their abstinence from insecticide use mandatory.

As a followup to the study, another is planned next year in the same seven counties, plus another six, with the help of the counties' extension agents, who procured this year's volunteers, and area health professionals who collected blood samples.

FAMILY MEDICINE UPDATE — September 16, 1978, Holiday Inn, Red Oak, Iowa, 5 Credit hours. Discussion includes pediatric orthopedics, acute trauma, topics in cardiology and obstetrics.

FAMILY MEDICINE UPDATE — September 30, 1978, Lutheran Community Hospital, Norfolk, Nebraska, 6 Credit hours. Topics include: pediatric orthopedics, general pediatric problems including: pneumonia, croup etc. and also problems of the newborn.

FAMILY MEDICINE UPDATE — December 7, 8 & 9, 1978, Omaha, Nebraska.

Sponsored by: Creighton University School of Medicine. For information contact: Office of Continuing Medical Education, Creighton University, Omaha, Nebraska 68178, (402) 449-2550.

An important message from Blue Cross and Blue Shield

We often refer to history to help solve many of today's problems. So let's take a brief look at the history of Nebraska Blue Shield.

This organization was organized by physicians for the benefit of the public. It was their method of countering government pressure for a national health insurance program. Obviously, physicians were concerned with the right to practice medicine in a self-controlled rather than a governmentally-controlled environment. They were more concerned, however, about the effect of a governmental program of such dimensions upon the health care of the American public.

As a result, physicians formed Nebraska Blue Shield.

An organization that would make physicians coverage available to the public on a mass marketing basis, utilizing the group mechanism. And by meeting the everchanging needs of the general public, this voluntary prepayment arrangement still works.

However, we are faced again with the government wanting to replace the proven and successful voluntary system with another one that has been disastrous world-wide. And again, it's up to you, the physician and an organization, now known as Blue Cross and Blue Shield of Nebraska, to help prevent this unwanted intervention.

And again, there's a realistic solution.

A solution that will not only help preserve the voluntary health care system, but, will, at the same time, satisfy the needs of physicians and their patients.

It's called the Physician's Voluntary Cost Effectiveness Agreement. An agreement which allows physicians to determine their own fees and assures them of fair and adequate reimbursement of their fees.

It's fair. Fair for everyone. And with your support...it can work.

So, study the information that was sent to you. Then call us if you have any questions. And if you have no questions...sign the Physician's Voluntary Cost Effectiveness Agreement and return it to us.

It'll be your personal effort in helping to maintain the delivery of quality care in a voluntary system that gives everyone a free choice.

Answers to some questions you may have

- What if the physician's usual fee is above the customary range, but the patient agrees to the specific fee before services are rendered?

In such cases of prior agreement, the physician can bill the patient for the balance.

- What if a physician has a disagreement and wants to appeal?

He can request review by either the NMA's peer review mechanism or an arbitration committee selected by himself and the Blue Cross and Blue Shield Plan.

- What about a complicated or unusual case with higher fee?

These cases will be considered individually and payment above the usual and customary fee can be provided.

- Will fees of physicians who choose not to volunteer for this program be paid a lesser rate?

No. The allowances are the same for all physicians fees with the payments made directly to the volunteering physicians, and to the Subscriber if the physician chooses not to volunteer.



ge to all physicians n Shield of Nebraska

Will specialist fees be mixed in with others who have less training and experience?

Specialists' fees are kept separately. The definition states: "Customary is defined as that range of usual fees charged by Physicians of similar training and experience for the same service within a given specific limited geographic or socioeconomic area." In addition, the fees of specialists are classified into two areas: (1) Omaha and Lincoln, and (2) the rest of the state. This methodology is designed to reflect any variance of fees by specialty and socioeconomic area. If the fees for a given service vary by specialty and area, the Usual and Customary allowances will likewise vary. Conversely, if the fees are similar, so will the allowances be similar. (Some fees are higher in category (2) than in (1) in certain cases.)

Why does your Company think it has a right to set physician's fee?

We don't set fees. Only the physicians do this. From these fees, we determine the Usual and Customary allowances.

Will physicians have the same problems with Welfare, the Veterans Administration, Medicare and other insurance companies who arbitrarily set Usual and Customary allowances below physician's fees?

We administer Usual and Customary differently than other thirdparty payors. Our method calls for using only actual fee data of Nebraska physicians, updating profiles annually, and paying on the 90th percentile basis. Also, if a physician's fees on a given case are above the Usual and Customary allowance, we advise him of this in advance of payment being made so if there were complications or other unusual circumstances, he can let us know so individual consideration can be given to the case. This can avoid problems with patients who aren't even aware of this situation since this correspondence with the physician is exchanged before payment is made and notice of such payment is given to the patient.

What about physicians who just started practicing a short time ago and whose expenses are higher than older physicians. As a result, newer physicians would have higher fees. Will new physicians' fees be mixed in with older physicians and thus get paid less?

Our method calls for paying on the 90th percentile basis. To say it another way, if only 10% of the physicians in the area charge higher fees than the older physicians, their fees will still be paid.

The contract says physicians have to accept your payment as a full payment, but many of your contracts only pay 80%. Why should physicians discount their fees 20% for your members?

The 20% coinsurance is the responsibility of the patient to the physician. Likewise the deductible, if any.

What about collecting Reasonable fees in full when they aren't entirely covered by your program?

The coinsurance or deductible, if any, as well as services not covered under the contract, are the patient's responsibility. Also, the contract provides that if arrangements are made with the patient on the specific fee prior to the covered services being performed, the patient is then responsible for any agreed upon fee over the Usual and Customary allowance.

In addition, on any disagreements, the physician can use the NMA's peer review mechanism or an arbitration committee, whichever he or she chooses, to resolve the issue.

Cross
Shield

Nebraska

Between Cases

The Prognosis.

Severe arthritis resulting in ability to safely walk without assistance.

Section On Pain.

Indeed, parental influences may be decisive factors in determining the amount of pain their children will suffer from minor injuries throughout the rest of their lives.

W. K. Livingston: What is pain?

Division Of Hospital Beds.

Private, she said quickly, picturing grim hospital rooms where two strangers were locked in mutual hostility and humiliation.

Elizabeth Cullinan: The sum and substance.

The Diagnosis.

Normal liver function tests with a damaged liver.

Quote Unquote.

It's like when you go to a good doctor, you know, and he reassures you.

H. Kane: Ghost story.

Gereology, Geriatrics.

Growing old is like driving backwards down a long, dark tunnel. You think you are seeing further when you are only seeing less.

Neil Boyd: Bless me, Father.

Heard On TV.

You and me will be going.

You and me will need . . .

Not me.

Section On Cardiomegaly And Hypertension.

Heart not enlarged, no murmurs, and rhythm regular. Pulses normal. 142/74. Not exercised; because of cardiac enlargement and hypertension.

Words I Can Do Without.

Comprise, interestingly, ratiocination, genre, horrendous, angst.

On Sensitivity.

He had become sensitive to human life, and that was disaster for a doctor.

From: The doctor game; by H. A. Olgin, M.D.

Department Of Definitions.

EKG: ticker tape.

Section On Weeds, Or Flowers I Don't Like.

The cost-of-living rose.

The Patient, In Writing.

I am going to have my gobalter out.

Section On Testing.

When given a graphic word upside-down, patient will consistently turn it upside right.

Upside right; that can't be right.

—F.C.

Books



Current obstetric & gynecologic diagnosis & treatment; edited by Ralph C. Benson, M.D.; 977 pages; limp cover \$18.00; published July 1978 by Lange Medical Publications, Los Altos, California 94022.

This is a second edition, the book having first appeared in December, 1976. It is divided into no less than 43 chapters, and it is written by 42 authors. There is an index, and there are many figures. There are unnumbered references. Printing is good, and reading is easy.

The chapter on contraception and family planning is essentially new, and so is the chapter on infertility. The first edition was barely on their desks, the editor says, when most of the authors started to revise their chapters. There is an appendix, too, on antimicrobial chemotherapy. I liked the section on the newborn infant, even before I read the recommendation there of Cole endotracheal tubes, but I like that, too.

The book is recommended.

—F.C.

Physicians' Classified

Advertisements in this column are run at a rate of twenty cents per word with a minimum of \$10.00 per insertion. Copy must be received by the fifth of the month preceding date of publication and should not exceed 50 words. Each advertisement will be taken out following its first appearance unless otherwise instructed. Where numbers follow advertisements, replies should be addressed in care of The Nebraska Medical Journal, 1902 First National Bank Building, Lincoln, Nebraska 68508.

PSYCHIATRIC RESIDENCY: Vacancies for (PG2 through PG4 only) positions starting September 1, 1978, and January 1, 1979, for those who have a regular Iowa license or can obtain one by reciprocity or via FLEX. Prepare for career in private practice, community clinics or hospital-based psychiatry. Emphasis on close supervision of intensive individual and group psychotherapy, OPD, Children's Unit, Adolescent Unit. Neurology affiliation with University of Iowa. The stipends are: 1st year, \$22,360; 2nd year, \$23,478; 3rd year \$24,674. Intensity and diversity of training program appreciated best by personal visit. T. B. McManus, M.D., Superintendent, Mental Health Institute, Cherokee, Iowa 51012. Equal Opportunity Employer. Call collect 712-225-2594.

SIOUX FALLS FAMILY PRACTICE RESIDENCY is seeking a full-time assistant director. Position open immediately. Program size presently 28 residents enlarging to 36. A strong

affiliation exists with the University of South Dakota School of Medicine and appointments to the faculty are available. Board certification required and experience in Family Practice desirable. Salary negotiable. Send resume to L. J. Sweeney, M.D. or Howard Hoody, M.D., 1800 South Summit Avenue, Sioux Falls, SD 57105. (605) 339-1783. Equal opportunity/affirmative action employer.

MEDICAL DIRECTOR — General practitioner to perform general examination, care, and treatment of patients at state psychiatric hospital. Forty-hour week with rotating on-call duty. No surgery. Starting salary of \$41,000 to \$45,000, depending on experience. Excellent benefits. Contact: H. D. Herrick, M.D., Superintendent, Norfolk Regional Center, Box 1209, Norfolk, Nebraska 68701. Call Collect: 402-371-4343.

PHYSICIAN: Regular Hours; excellent fringe benefits; will join three other physicians in a progressive facility serving developmentally disabled persons; must meet South Dakota licensing requirements; salary in excess of \$40,000 (negotiable). Contact: Dr. Verle Rogers, Superintendent, Redfield State Hospital and School, Redfield, South Dakota 57469, (605-472-2400). An Equal Opportunity Employer.

Coming Meetings

CRIPPLED CHILDREN'S CLINICS —

September 30 — Ainsworth, Elementary School

October 7 — Alliance, Central School Building

NEBRASKA MEDICAL ASSOCIATION —

Fall Session, September 22-24, 1978, Lincoln Hilton Hotel, Lincoln, Nebraska.

RADIOLOGISTS MEET —

The Society of Gastrointestinal Radiologists is conducting a postgraduate course on "Diagnostic Imaging of the Gastrointestinal Tract" at Tan-Tar-A, Lake of the Ozarks, Missouri from October the 12th to October the 15th, 1978. The faculty will be drawn from the membership of the Society of Gastrointestinal Radiologists and includes leading academic radiologists from the entire country. The registration fee is \$225. The course is co-sponsored by the American College of Radiology with approval for category I credit of 13 hours. Further information and application materials can be obtained from the president of the society, Walter M. Whitehouse, M.D., Department

of Radiology, University of Michigan Hospital, Ann Arbor, Michigan 48109

OMAHA MID-WEST CLINICAL SOCIETY:

46th Annual Postgraduate Assembly; Omaha Hilton Hotel; October 30, 31 and November 1, 1978. Write to: Lorraine E. Seibel, Executive Secretary, Omaha Mid-West Clinical Society, 540 Medical Arts Building, Omaha, Nebraska 68102.

AMERICAN MEDICAL ASSOCIATION —

Interim Session, House of Delegates, December 2-6, 1978, Palmer House, Chicago, Illinois.

AMERICAN MEDICAL ASSOCIATION —

Winter Scientific Program, December 7-10, 1978, Las Vegas, Nevada.

NEBRASKA MEDICAL ASSOCIATION —

Annual Session, April 29 - May 2, 1979, Holiday Inn, Kearney, Nebraska.

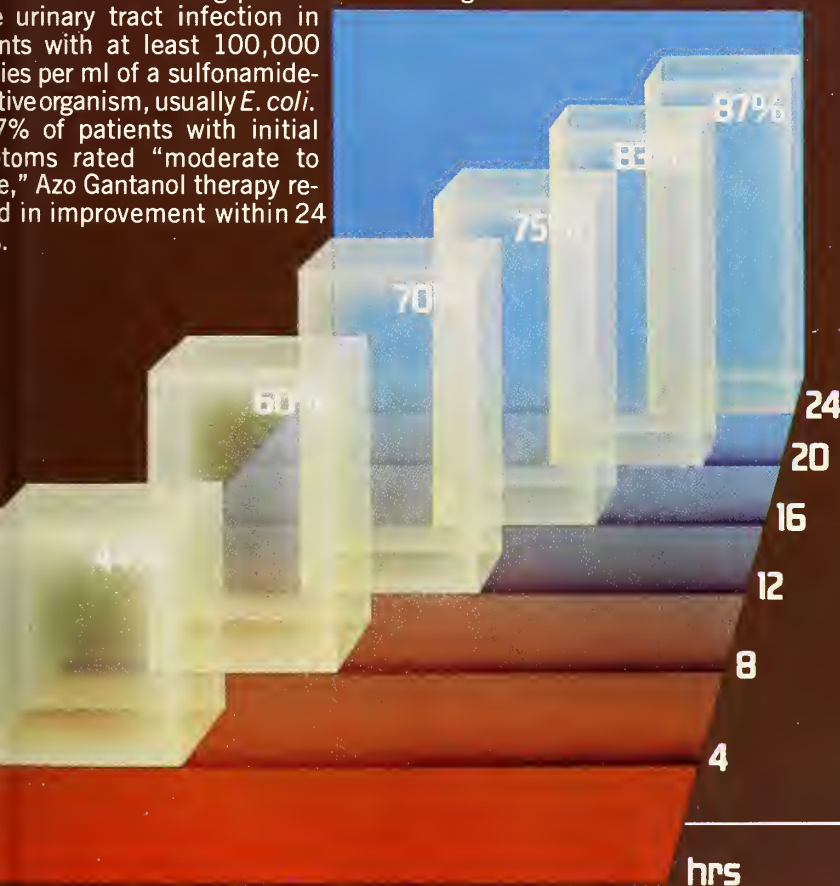
AMERICAN MEDICAL ASSOCIATION —

Annual Convention, July 22-26, 1979, Chicago, Illinois.

Important data on the pain of acute cystitis:

87% of patients
studied (303 of 349),
Azo Gantanol® reduced
pain and/or burning
within 24 hours*

Controlled, multicenter study assessed the efficacy of
Azo Gantanol in relieving pain and/or burning associated with
the urinary tract infection in
patients with at least 100,000
organisms per ml of a sulfonamide-
sensitive organism, usually *E. coli*.
87% of patients with initial
symptoms rated "moderate to
severe," Azo Gantanol therapy re-
sulted in improvement within 24



For pain relief plus effective antibacterial action

Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

for
the pathogens
causing
pain

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note:** Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat; fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

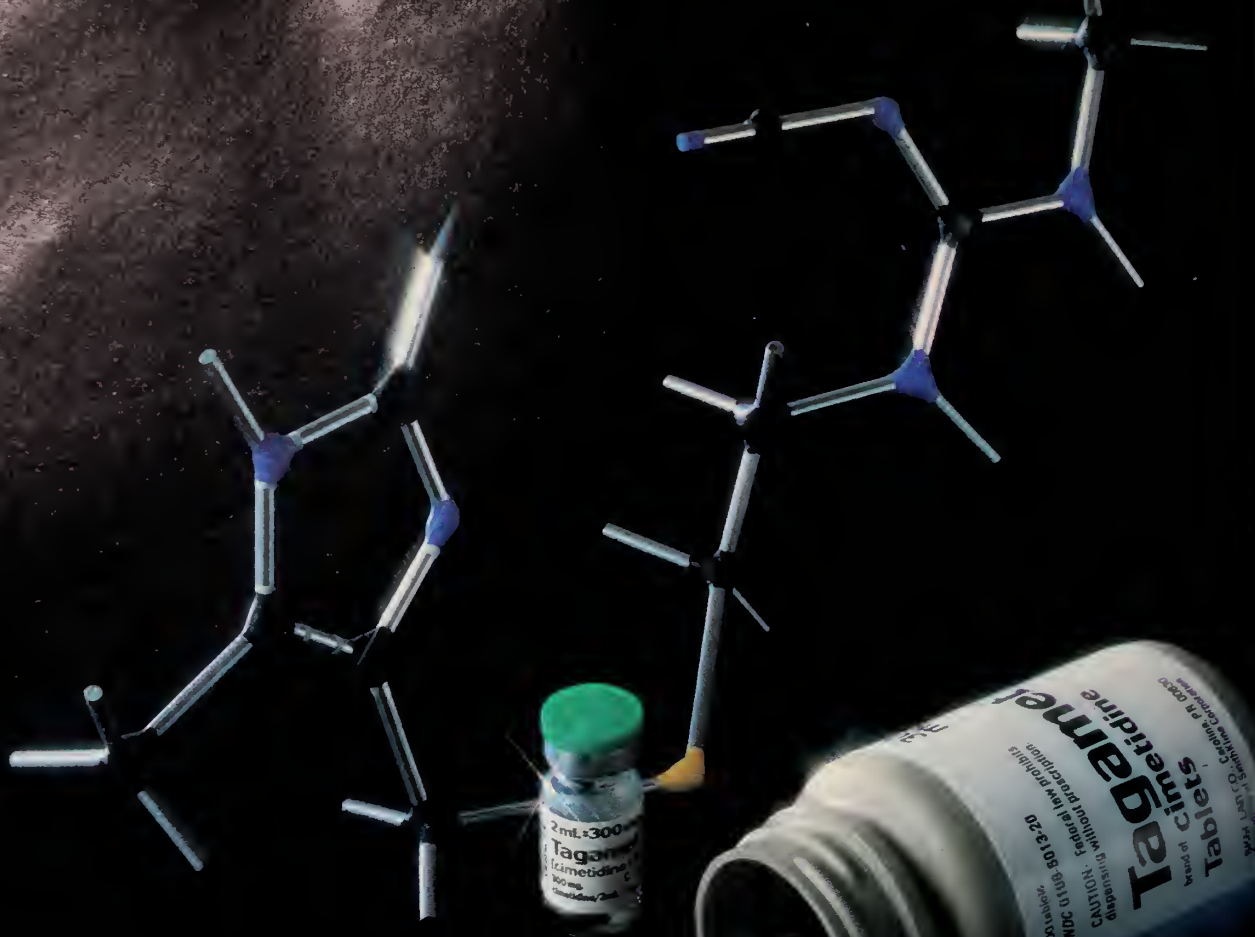
Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.



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cimetidine

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the most common complaint you'll see this winter?

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when patients want it... *stat*

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EMPIRIN[®] COMPOUND c CODEINE

Each tablet contains— aspirin, 227 mg, phenacetin 162 mg, and caffeine 32 mg; plus codeine phosphate in one of the following strengths: #4—60 mg (gr 1); #3—30 mg (gr ½); #2—15 mg (gr ¼), and #1—7.5 mg (gr ⅛). (Warning—may be habit forming).



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In Memoriam

*By medicine life may be prolong'd
yet death*

Will seize the doctor too.

—Shakespeare

DR. JAMES J. LEAHY

Doctor James J. Leahy died on February 19, 1978, at the age of 57. Doctor Leahy was born in Butternut, Wisconsin, on February 27, 1920.

He graduated from Northwestern University Medical School in 1945. He practiced in Park Falls, Wisconsin, until 1959, when he established his practice in Omaha.

He is survived by his wife, Kay; sons, Kevin of Oahu, Hawaii, and James, Robert and David of Omaha; daughters, Mrs. David Filipi, Janet and Marcia, all of Omaha; brother, mother and grandchildren.

DR. HORACE V. MUNGER

Doctor Horace V. Munger died on February 12, 1978, at the age of 65. He was born in Eagle, Nebraska, on March 12, 1912.

He graduated from the University of Nebraska College of Medicine in 1937. Doctor Munger interned at Bellevue Hospital in New York City and took residency training in urology at Turner Urological Institute in Houston.

In 1946, he returned to Lincoln where he practiced until he retired and moved to Cedaredge, Colorado.

Doctor Munger began his service as Secretary-Treasurer of the Nebraska Medical Association in 1963 until he was elected Vice President in 1968 and named President-Elect in 1971.

He is survived by his wife, Margaret A.; sons, Michael Paul and Kenneth, both of Lincoln; daughters, Myrtie Jo Webb, of Dayton, Ohio, and Maralie Rowell of Wescosville, Pennsylvania; brother, Irvia of Borrego Springs, California; sister, Marguerite Millikan of Green Valley, Arizona; and six grandchildren.

DR. CHESTER H. WATERS, SR.

Doctor Chester H. Waters, Sr. died on March 25, 1978, at the age of 93. Doctor Waters was born in Warsaw, Illinois, on December 11, 1884.

He graduated from Cornell University Medical School in 1912 and following his surgery internship at New York Hospital, he established his surgery practice in Omaha.

He is survived by a daughter-in-law, Mrs. Chester H. Waters, Jr., Omaha; grandson, Dr. Chester H. Waters, III, Kansas City, Kansas; granddaughter, Katherine Waters, Falls Church, Virginia; niece, Mrs. William Harkins, Neighborville, Illinois; and nephew, John Waters, Peoria, Illinois.

Picture Gallery

NMA 1978 Annual Session



Doctor Charles W. Landgraf, Jr., escorting Mrs. Guy M. Matson to lectern.



Mrs. Guy M. Matson addressing House of Delegates.



Doctor Gordon D. Francis addressing House of Delegates.



Doctor Richard A. Cottingham introducing guest speakers, Doctors Charles M. Winget and John R. Beljan.



Symposium moderator, Doctor Richard A. Cottingham; guest speakers, Doctors Charles M. Winget and John R. Beljan and Doctor Joseph M. Holthaus, Dean, Creighton University School of Medicine.



Doctor Bruce F. Claussen addressing House of Delegates.



Doctor Arnold W. Lempka escorting Doctor Charles W. Landgraf, Jr. to lectern.



Doctor Arnold W. Lempka congratulating the new President-Elect, Doctor Charles W. Landgraf, Jr.

Picture Gallery

NMA 1978 Annual Session



Doctor Arnold W. Lempka presenting President-Elect badge to Doctor Charles W. Landgraf, Jr.



Doctors Arnold W. Lempke, Houtz G. Steenburg and Charles W. Landgraf, Jr.



Exhibit area.



Exhibit area.



Exhibit area.



Exhibit area.



Exhibit area.



Exhibit area.

WashingtonNotes

Kennedy, labor, Carter, NIH, & the AMA.

Kennedy-Labor forces upstaged President Carter's release of national health insurance principles by denouncing them as unacceptable overall a day before they were to be made public.

Senator Edward Kennedy (D-Mass.) and AFL-CIO President George Meany in a joint press conference a day before the scheduled release of the NHI principles charged Carter with a failure of leadership and of misreading the mood of the people.

A day later President Carter called for a NHI plan that through a step-by-step process would ultimately lead to comprehensive health coverage for all. He directed Health, Education, and Welfare Secretary Califano to develop a tentative plan as soon as possible which embodied 10 White House derived NHI principles.

James H. Sammons, M.D., Executive Vice President of the AMA, stated:

"The American Medical Association is pleased that the President appears to have recognized the many positive aspects and strengths of our health care system in the process of presenting his national health insurance principles. Many of the NHI principles announced by the President seem to be consistent in whole or in part with similar principles that have been endorsed by the American Medical Association. These include the need for comprehensive health care coverage, freedom of choice of physician, hospital, and health care delivery system, the provision of quality care, and the utilization of the private health insurance industry. The AMA has introduced legislation embodying these principles in the Congress since 1970."

The President's NHI principles:

1. The plan should assure that all Americans have comprehensive health care coverage, including protection against catastrophic medical expenses.

2. The plan should make quality health care available to all Americans. It should seek to eliminate those aspects of the current health system that often cause the poor to receive substandard care.

3. The plan should assure that all Americans have freedom of choice in the selection of physicians, hospitals, and health delivery systems.

4. The plan must support our efforts to control inflation in the economy by reducing unnecessary health care spending. The plan should include aggressive cost containment measures and should also strengthen competitive forces in the health care sector.

5. The plan should be designed to that additional public and private expenditures for improved health benefits and coverage will be substantially offset by savings from greater efficiency in the health care system.

6. The plan will involve no additional federal spending until FY 1983, because of tight fiscal constraints and the need for careful planning and implementation. Thereafter, the plan should be phased in gradually. As the plan moves from phase to phase, consideration should be given to such factors as the economic and administrative experience under prior phases. The experience of other government programs, in which expenditures far exceeded initial projections, must not be repeated.

7. The plan should be financed through multiple sources, including government funding and contributions from employers and employees. Careful consideration should be given to the other demands on government budgets, the existing tax burdens on the American people, and the ability of many consumers to share a moderate portion of the cost of their care.

8. The plan should include a significant role for the private insurance industry, with appropriate government regulation.

9. The plan should provide resources and develop payment methods to promote such

major reforms in delivering health care services as substantially increasing the availability of ambulatory and preventive services, attracting personnel to underserved rural and urban areas, and encouraging the use of prepaid health plans.

10. The plan should assure consumer representation throughout its operation.

AMA, HEW, & hospital cost control.

After more than two months of bitter struggle within a seesawing House Commerce Committee the Administration's hospital cost control bill has suffered a crippling and probably fatal blow.

The House Commerce Committee has stunned the Administration by voting 22 to 21 to remove the threat of federal controls from its measure. The Committee then approved 15 to 12 a substitute bill asking hospitals to cut revenue increases by two percent a year and establishing a Presidential Commission to oversee the situation. States would receive financial aid for their own cost control programs if they wish.

HEW Secretary Califano said the committee action was a defeat for the public interest and a victory for the special hospital interests. He told a news conference he will talk to Congressional leaders "to assess our ability to obtain a meaningful bill from Congress this year."

Health provider groups, led by the AMA, the American Hospital Association and the Federation of American Hospitals, were in the forefront of the drive to block the bill. Commenting on the Committee's action, Robert B. Hunter, M.D., AMA Board Chairman said the AMA "is pleased to learn that the efforts of the private sector, through the Voluntary Effort and other cost consciousness programs, has been recognized by Congress. This kind of coordinated and cooperative effort between physicians and hospitals to cut the rise in the escalation of health care costs is the only responsible approach to the continued delivery of quality health care."

Curtis & HMOs.

The Senate has approved a scaled-down measure continuing federal aid for Health Maintenance Organizations (HMOs).

Reports of abuses of the HMO program in some areas led the Senate to adopt financial disclosure provisions and other rule tightening. As cleared by the Senate, the HMO program would be extended for three years with a total authorization of \$170 million. The original request had been for a five-year extension and \$400 million.

There was only one dissenting vote on final passage — by Sen. Carl Curtis (R-Nebr.) who said efficient HMOs don't need subsidies and there are "too many instances of fraud and abuse among subsidized HMOs . . ."

The measure, which now goes to the House, would increase the maximum grant or loan guarantee, for an initial HMO project from \$1 million to \$2 million; would allow twice as much in aggregate initial operating loans and guarantees to be outstanding (\$5 million, up from \$2.5 million); relax certain benefit requirements; and establish a HEW Department monitoring system to police the program.

AMA & the Voluntary Effort.

A dramatic decline in hospital inflation has "clearly demonstrated that the private sector" can handle the task of curbing rising costs, said James Sammons, M.D., AMA Executive Vice President.

Dr. Sammons and other officials connected with the Voluntary Effort (VE) told a Washington, D.C. news conference that April figures revealed that for the eighth consecutive month the rate of increase in hospital expenditures has been braked.

John Alexander McMahon, AHA President, said the figures demonstrate that the Voluntary Effort is alive and well.

Neighbor or community health centers.

The government's \$200 million Neighborhood Health Center program is overstaffed, the General Accounting Office (GAO) has charged.

The GAO, which investigates federal programs for Congress, said the "underuse of physicians, dentists, support personnel and services is costing the six centers to date investigated more than \$1 million annually."

The HEW Department operates 112 Community Health Centers primarily in urban areas. GAO said the annual salary costs for excess primary care physicians at the centers is above \$4 million. Costs for excess supporting staff were estimated to be \$6.3 million.

At 58 percent of the centers, the average number of patients treated by physicians per

hour fell below HEW's minimum standard of 2.7 per hour, according to GAO.

In a report to Congress, GAO said anticipated patient demand on which staff levels were originally based has not materialized, and staffs have not been reduced to levels consistent with demand.

Medicaid & abortions.

The government has issued rules under which federal funds may be used to pay for Medicaid abortions.

The two physicians who certify necessity of the abortion must be financially independent of each other to eliminate conflicts of interest. Under law, federal funds may be used for abortions only when two physicians certify the mother will suffer severe and long-lasting damage.

Prognosis in Patients Rejected for Coronary Revascularization Surgery — H. Gross et al (M. V. Cohen, Div of Cardiology, Montefiore Hosp and Medical Center, Bronx, NY 10467) *Am J Med* 64:9-20 (Jan) 1978.

The clinical course, catheterization data, and coronary and left ventricular angiograms of 231 patients rejected for coronary revascularization surgery between 1971 and 1974 and treated conservatively were evaluated. The patients were classified into one of eight groups as follows: poor left ventricular function, atherosclerotic distal coronary vessels, advanced age, isolated stenosis of the left circumflex coronary artery, nonjeopardized collaterals to myocardium beyond the critical coronary stenosis, akinetic or dyskinetic myocardium beyond the critical coronary stenosis, and coronary lesions of 50% to 74% of the luminal diameter; 50 patients were considered acceptable surgical candidates. At three years the actuarial survival rate for all patients was 77.6%. However, those considered operable had a 36-month survival rate of 97.9%. Ejection fraction was the only hemodynamic or clinical feature which had significant prognostic value. The probability of survival for three years was 89.7% for those with ejection fractions greater than 34%, whereas in others the survival rate was only 59.0% ($P < .001$). When subdivided according to left ventricular function, there was little difference in survival rates for patients with ejection fractions in excess of 34% and one, two, or three vessel disease. In patients with poor ventricular function survival rates were similarly low irrespective of the extent of coronary obstructive disease.

Medical Management of Angina Pectoris — G. E. Burch (Charity Hosp of Louisiana, New Orleans, LA 70118) *Angiology* 28:813-816 (Dec) 1977.

Angina pectoris is a clinical syndrome which is typical in only about 65% of patients; it may be silent (without discomfort such as pain, pressure, tightness, heaviness, and burning) in 10% to 20% of patients. The diagnosis of angina pectoris can be made only through a carefully recorded history. Effective therapy is possible only when the treating physician is solely responsible for

the history, physical examinations, and interpretation of all laboratory data. The therapeutic objective is to outline a regimen that will eliminate all episodes of angina pectoris. If the patient is having repeated episodes of angina on the slightest provocation, he should be restricted to bed rest and isolated from visitors, telephone calls, and business discussions. The patient's meals should consist of small feedings of "sick people's food." A fresh 0.3 mg nitroglycerin tablet should be placed at the bedside for sublingual use immediately at the onset of anginal discomfort, regardless of what the discomfort is. Sedatives may be used as indicated. Anticoagulant therapy should not be used. Caffeine beverages, tobacco, and alcohol should be forbidden. Oxygen may be employed for psychogenic reasons if necessary.

Does Coronary Bypass Increase Longevity?

— O. W. Isom et al (Depts of Surgery and Medicine, New York Univ School of Medicine, New York, NY 10016) *J Thorac Cardiovasc Surg* 75:28-37 (Jan) 1978.

The authors studied 1,174 consecutive patients who had elective coronary bypass surgery between 1968 and 1975 (98% follow-up). Most patients were operated on for disabling angina refractory to medical therapy. Patients undergoing concomitant valve replacement, ventricular aneurysmectomy, and emergency bypass surgery were excluded from this analysis. The overall operative mortality was 5.2%, decreasing from 28% in 1968 to 2% to 3% in the last three years (1972 to 1975). Multiple grafts (two to six) were used in 88% of the group. Angina was cured or greatly improved in 92% of surviving patients. The five-year survival rate (compared by life table analysis including operative deaths but excluding late, noncardiac-related deaths) was high (88%). Only 49 deaths from cardiac causes occurred after dismissal from the hospital in the 1,174 patients. Nonfatal myocardial infarctions were similarly uncommon, 2.6% (actuarial analysis). These data show a better survival rate than do previous surgical reports (average late mortality of 3% per year) and a much greater survival rate than for medically treated patients with double or triple artery disease (five-year mortality of 35% and 55%, respectively).

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As physicians you know the importance of proper diagnosis and treatment. When your patient requires a prescription for an orthopedic support or appliance, you also know the importance of a proper fitting.

Jim Arntzen, R.P., is one of Nebraska's few certified fitters of orthopedic supports and appliances. Jim Arntzen is a professional... and that means your patient will not only be fitted properly, but in the appropriate support or appliance.



For a professional fit it's...

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Lincoln, Nebr. 68508

Common Manifestations of Cow's Milk Allergy in Children — P. D. Buisseret (Dept of Medicine, Guy's Hosp Medical School, London, England) *Lancet* 1:304-305 (Feb 11) 1978.

Cow's milk allergy was diagnosed in 79 patients, all of whom had signs and symptoms of allergies other than milk intolerance. In addition to difficulties with infant feeding and diarrhea, clinical features included constipation, vomiting, intestinal colic, growth retardation, and psychological disturbance, as well as eczema and asthma. All were reversible after milk withdrawal, which suggests that the allergic basis of such symptoms may have been underestimated. In most cases, one or both parents were atopic and the child had been bottle-fed from birth. There were no breast-fed children on non-atopic parents in this series.

This day, which thou fearest as thy last, is the birthday of eternity.

Seneca.

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For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days



- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice

- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (Federal Register, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprote thrombinemia and methemoglobinemia. Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. CNS reactions: Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight	Dose—every 12 hours	
	Teaspoonfuls	Tablets
lbs		
20	1 teasp. (5 ml)	½ tablet
40	2 teasp. (10 ml)	1 tablet
60	3 teasp. (15 ml)	1½ tablets
80	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).



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Please see back cover.

Her next attack of cystitis may require

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October, 1978

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; ataxosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the patient's condition.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma. May be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals from obtaining the drug. Keep addiction-prone individuals from obtaining the drug. Keep addiction-prone individuals from obtaining the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated. In cerebral atrophy or liver disease, limit dosage to smallest effective amount. **Side Effects:** Drowsiness, confusion, ataxia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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EDITOR-FRANK COLE, M.D., No. 13, Bishop Square
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Hospital Discharge One Week After Acute Myocardial Infarction — J. F. McNeer et al (Duke Univ Medical Center, Durham, NC 27710) *N Engl J Med* 298:229-232 (Feb 2) 1978.

Sixty-seven consecutive patients who had suffered an acute myocardial infarction but no serious complications during the first to fourth hospital days were considered for a trial of hospital discharge at one week. Thirty-three patients were discharged at one week, the remainder having a mean hospital stay of 11+2 days. The incidence of late complications and recurrent infarctions, as well as mortality and functional status, were determined in all patients six months after discharge. No serious complications occurred in either subgroup within three weeks after discharge. There were no deaths and no difference in functional status at six months. Patients without serious complications during the four days after an acute myocardial infarction can be spared the economic costs and psychologic stress or prolonged hospitalization.

The Concorde and Cosmic Rays — J La-Vernhe et al (Medical Dept, Air France, Paris, France) *Aviat Space Environ Med* 49:419-421 (Feb) 1978.

In 1976, Air France's Concorde's operated 2,652 hours of flight time during 772 commercial flights to Rio de Janeiro, Caracas, and Washington. The cosmic radiation dose equivalent rate was measured during each of these flights. The average amount recorded was 0.99 mrem/h. A distinction must be made between the high latitudes (Washington route), on which an average dose equivalent rate of 1.49 mrem/h was recorded, and low latitudes (Rio de Janeiro and Caracas route), on which the average dose equivalent rate was only 0.78 mrem/h. These figures show that 1976 Concorde passengers and crews were exposed to very low quantities of radiation — very much lower than the maximum value recommended for the general public, which is 500 mrem per year.

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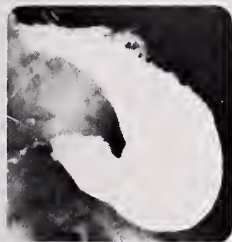
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"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating certain functional G.I. disorders.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Brief Summary
INDICATIONS

For use as adjunctive therapy in the treatment of peptic ulcer
IT SHOULD BE NOTED AT THIS POINT IN TIME THAT THERE IS A LACK OF CONCURRENCE AS TO THE VALUE OF ANTICHOLINERGICS/ANTISPASMODICS IN THE TREATMENT OF GASTRIC ULCER. IT HAS NOT BEEN SHOWN CONCLUSIVELY WHETHER ANTICHOLINERGIC/ANTISPASMODIC DRUGS AID IN THE HEALING OF A PEPTIC ULCER, DECREASE THE RATE OF RECURRENCES, OR PREVENT COMPLICATION

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

May also be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders); and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon)

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup)

Final classification of the less-than-effective indications requires further investigation

CONTRAINDICATIONS Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloro-duodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis, myasthenia gravis. **WARNINGS** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: autonomic neuropathy, hepatic or renal disease, ulcerative colitis—Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon; hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension; hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis). Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. **ADVERSE REACTIONS** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia, urinary hesitancy and retention, blurred vision and tachycardia, palpitations, mydriasis; cycloplegia, increased ocular tension; loss of taste, headache, nervousness; drowsiness; weakness, dizziness, insomnia, nausea, vomiting, impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations, some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSAGE AND ADMINISTRATION** Dosage must be adjusted to individual patient's needs.

Usual Dosage Bentyl 10 mg capsule and syrup. Adults 1 or 2 capsules or teaspoonfuls syrup three or four times daily. Children 1 capsule or teaspoonful syrup three or four times daily. Infants ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg. Adults 1 tablet three or four times daily. Bentyl Injection. Adults 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. **MANAGEMENT OF OVERDOSE** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of October, 1976

Skeletal Trauma in Skateboard Injuries — R. W. Hawkins (Henry Ford Hosp, Detroit, MI 48202) and E. D. Lyne, Am J Dis Child 132:751-752 (Aug) 1978.

Thirty fractures resulting from skateboarding have been treated in the past six months at the Henry Ford Hospital, Detroit. Although there have been no serious or unusual injuries, this represents a substantial increase over the previous year. Awareness of the hazards of this sport is the first step in reducing the frequency and seriousness of these injuries. As a result of this experience, safety guidelines for skateboarding are recommended for the parents of enthusiasts.

Legionnaires' Disease: Structural Characteristics of the Organism — S. M. Katz (Hahnemann Medical College and Hosp, Philadelphia, PA 19102) Science 199:896-897 (Feb 24) 1978.

The Legionnaires' disease organism was isolated from lung tissue taken from two fatalities of the Legionnaires' disease epidemic that occurred in Philadelphia during 1976. In yolk sac tissue the agent grew as a small coccobacillary microorganism, which was Gram variable and Gimenez positive. Intracellular coccoid and bacillary forms, detected by electron microscopy, within and without vacuoles, underwent multiplication by septate binary fission. Some of the intracellular forms resembled obligate intracellular pathogens. On defined bacteriologic media, the organisms were predominantly bacillary. The organism conforms to the morphologic criteria of a prokaryocyte.

When I read rules of criticism, I immediately inquire after the works of the author who has written them, and by that means discover what it is he likes in a composition.

Addison.

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Yet have I something in me dangerous.

Hamlet.

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Tablets

Percodan® 

DESCRIPTION Each yellow, scored tablet contains 4.50 mg oxycodone HCl (WARNING: May be habit forming), 0.38 mg oxycodone terephthalate (WARNING: May be habit forming), 224 mg aspirin, 160 mg phenacetin, and 32 mg caffeine.

INDICATIONS For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS Hypersensitivity to oxycodone, aspirin, phenacetin or caffeine.

WARNINGS **Drug Dependence** Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of PERCODAN®, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, PERCODAN® is subject to the Federal Controlled Substances Act.

Usage in ambulatory patients Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using PERCODAN® should be cautioned accordingly.

Interaction with other central nervous system depressants Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with PERCODAN® may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Usage in pregnancy Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, PERCODAN® should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Usage in children PERCODAN® should not be administered to children.

Salicylates should be used with caution in the presence of peptic ulcer or coagulation abnormalities.

PRECAUTIONS **Head injury and increased intracranial pressure** The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions The administration of PERCODAN® or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special risk patients PERCODAN® should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

Phenacetin has been reported to damage the kidneys when taken in excessive amounts for a long time.

ADVERSE REACTIONS The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include euphoria, dysphoria, constipation and pruritus.

DOSAGE AND ADMINISTRATION Dosage should be adjusted according to the severity of the pain and the response of the patient. The usual adult dose is one tablet every 6 hours as needed for pain.

DRUG INTERACTIONS The CNS depressant effects of PERCODAN® may be additive with that of other CNS depressants. See WARNINGS.

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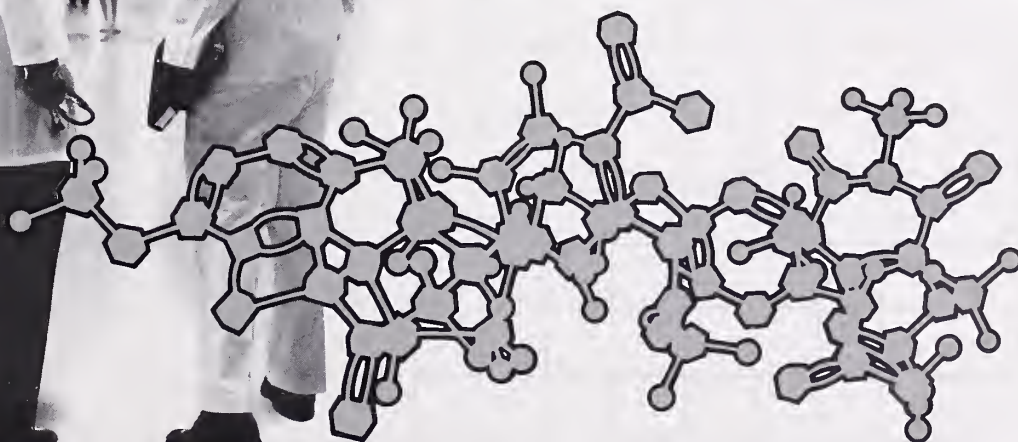
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Home-Testing for Recurrent Bacteriuria Using Nitrite Strips — D. W. Scheifele (Children's Hosp Medical Center, Boston, MA 02115) and A. L. Smith *Am J Dis Child* 132:46-48 (Jan) 1977.

Follow-up of children with recurrent urinary infections would be simplified by an accurate home-testing program for detecting infection. Nitrite test strips were provided to the parents of 30 girls with recurrent urinary infection to determine if twice weekly home testing of first-voided urine could reliably detect infection. Infections were documented by dip slides or colony counts indicating more than 105 bacteria per milliliter of urine. Twenty-four families (80%) complied over a mean study period of 11 months, detecting 28 of 30 episodes of bacteriuria (93%). No false-positive tests occurred. Urinary nitrate, the substrate for nitrite production by bacteria, was universally present ($>100 \mu\text{g/ml}$) in 80 children. The nitrite test is useful for home follow-up of children at high risk of bacteriuria if applied repeatedly by motivated parents.

It is foolish to pluck out one's hair for sorrow, as if grief could be assuaged by baldness.

Cicero.

* * *

Health and cheerfulness mutually beget each other.

Addison.

* * *

In nothing do men more nearly approach the gods than in giving health to men.

Civero.

* * *

Of all the garden herbes none is of greater vertue than sage.

Thomas Cogan.

Librax®

Each capsule contains 5 mg
chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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*Librax has been evaluated as possibly effective for this indication.
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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is

affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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Pancreatic Pseudocyst — E. W. Pollak et al
(8940 Nall Ave, Overland Park, KS 66207)
Am J Surg 135:199-201 (Feb) 1978.

The management of pancreatic pseudocyst was reassessed in 54 patients: 16 (30%) regressed with nonoperative management; six (11%) died of septic complications; and 32 (64%) eventually required operation. Most pseudocysts did not regress with nonoperative therapy, thus emphasizing the need of serial clinical and ultrasonic examination at frequent intervals to detect nonresolution or complications requiring earlier operation than previously advocated.

The ear is a less trustworthy witness than the eye.

Herodotus.

* * *

I have a good eye, uncle; I can see a church by daylight.

Much Ado About Nothing.

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Ben N. Greenberg, York

Effect of Weight Loss Without Salt Restriction on the Reduction of Blood Pressure in Overweight Hypertensive Patients. — E. Reisin et al (H. E. Eliahou, Tel-Aviv Univ Medical School, Tel-Hashomer, Israel) N. Engl J Med 298:1-6 (Jan 5) 1978.

Overweight patients with uncomplicated essential hypertension were followed bi-weekly for six months: 24 not receiving anti-hypertensive drug therapy (group 1) and 83 on regular but inadequate (despite drug manipulation) antihypertensive drug therapy (group 2). All patients in group 1 and 57 randomly selected patients from group 2 (2a) participated in a weight reduction program. The remaining 26 from group 2 (2b) did not receive a dietary program. Salt intake was in the normal range in all three groups. All patients on the dietary program lost at least 3 kg (mean, 10.5 kg), and all but two showed a meaningful reduction in blood pressure, 75% of group 1 and 61% of group 2a returned to normal blood pressure. The weight and blood pressure reductions were highly significant ($P < .001$), were present in both sexes and all ages, and were directly associated. In group 2b, no significant change in blood pressure or weight occurred ($P < .30$).

"Lethal" Burns — W. W. Monafó et al (Dept of Surgery, St John's Mercy Medical Center, St Louis, MO 63141) Arch Surg 113:397-401 (Apr) 1978.

Sixteen consecutive patients, none of whom also had inhalation injury, had burns over 72% body surface area or more. The expected death rate was 94%. All of the eight patients still alive after 48 hours survived. The early deaths were primarily due to inhalation injury, the treatment of which remains an unsolved problem. A mixture of cerium nitrate and silver sulfadiazine was used for topical wound antiseptis. The wound flora was sparse: 447 of 814 wound-surface cultures were sterile; Gram-negative bacteria were recovered in 13%. This efficacious wound bacteriostasis appeared primarily responsible for the absence of late death.

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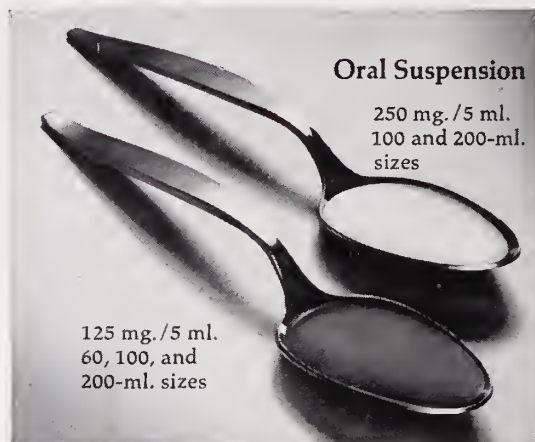
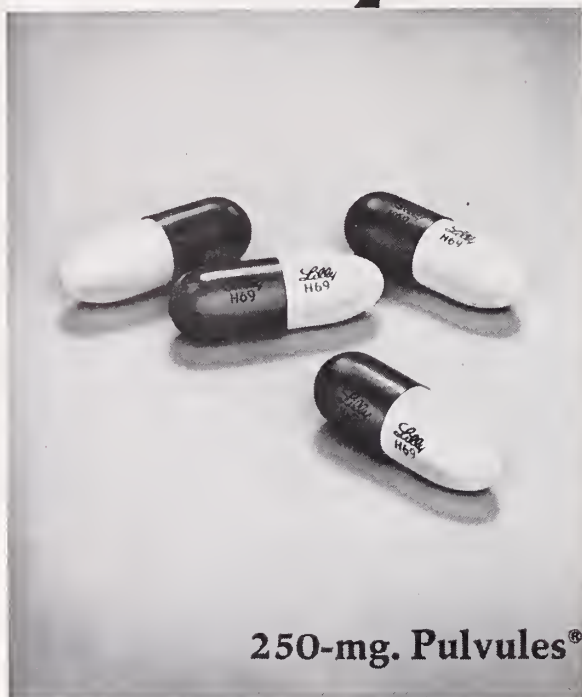
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THE NEBRASKA MEDICAL JOURNAL

DISEASE IS NATURAL

When you get edema of the lungs, everything in your body is going along according to natural and fixed laws, as always. Physical and physiological formulas and equations are adhered to, and if you cough or ache, you are supposed to cough and ache. When an artery is torn, blood will come out; and when you are kicked by a horse (for really good shock, you are supposed to be kicked by a horse), your blood pressure will fall and the pulse will go up. You may not like these things, but it is you who are wrong; these events are supposed to happen.

For disease is not wrong, it is right. All the chemical and physical actions that make up life obey the same laws of nature in disease that they do in health; and it is we who are wrong. A tumor may look beautiful under the microscope, and a pulse rate of 30 will come about naturally. And if we are to substitute one set of conditions for another, because one is pleasing, we will obey the same laws and equations. We cannot appeal to Higher Authority and point and say, We are hurting, and this is wrong. We are sure to be told, Yes, you are hurting, and No, this is not wrong. Do right, and it will go away.

—F.C.

RIGHT OF DOMAIN

O how I wish I had learned my medicine with more sense than memory; perhaps the fault stems from the need to pass examinations, where teaching and learning are better goals. So much of what we had to learn and to repeat parrot-like made no sense at the time and makes less now. We mispronounced cavernous when we referred to the sinus. We said shelving for hernia repair when we never used the word anywhere else, and did not even then understand the word. We learned to say imbricate where overlap will do; when else do we ever say imbricate? We described one division of the sympathetic nervous system as sympathetic. We repeated silly words like claudication, and did you ever hear of claudication that wasn't intermittent?

But do they still teach students to say right of domain? If centuries ago, surgical knowledge was too small to cope with a hernia that had been allowed to grow too long and too large, why do we now, when hernias are no longer carried in wheelbarrows, speak of right of domain? The hernias grew large because they couldn't be fixed when they were small, anyway.

We stopped imbricating and claudicating long ago, but our hernias never lost their right of domain.

—F.C.

WHEN DOES A DISEASE BEGIN?

If your blood has five percent more than normal of whatever the thyroid gland puts out, are you hyperthyroid, and are you diseased? If you have chest pain, and your EKG and enzymes are all right, are you sick? When your fasting blood sugar gets to 300, I am sure you have diabetes, but when did you *begin* to have diabetes? When does cancer start, when do you have bronchitis for the first time?

We are given to daydreaming, or to woolgathering, as we say where I grew up, I may check my stove or headlights more than once when I leave, but when am I neurotic? I may be unhappy with storeclerks, and when is my personality disordered?

Statisticians use 5% for significance, and 80% may be a good working rule in the body. If your BMR was within 80% of what we expected, when we took BMRs, you were probably healthy. And if the hemoglobin was within 80% of normal, you were probably normal. But maybe your blood sugar goes to 150 and comes down again, maybe your blood pressure rises or falls alarmingly and comes back to where it was; were you diseased? When does a disease become a full-fledged entity; when is a disease?

If the blood sugar is 130, should we treat it; if the hemoglobin falls to 12, must we correct it; if the patient forgets where he

puts things, is he sick? If he has three small drinks a day, is he a victim of alcoholism?

Begin at the beginning, the King said to Alice. If we only knew where it was.

—F.C.

MEDICINE AND THE GEOMETER

Mathematicians have invaded our domain; they have left us with lesser *curvatures*, sagittal *planes*, white *lines*, and lacrimal *points*. They have inflicted on us such things as the *circle* of Willis, the *triangles* of the neck, the visual *cone*, and the renal *pyramids*; and have us oriented in *spheres*.

We cannot escape their crossed *cylinders*, and their Curschmann's *spirals*, their *angle* of the sternum, nor yet the *ellipsoid* of the spleen. And we are left with motor *roots*, with *parallelism*, and with tendinous *intersections*.

And with *degrees*, like M.D.

—F.C.

ON PROFESSIONAL COURTESY

In the old days, which I remember, we didn't charge each other. There were others we didn't charge, too, but it is doctor-to-

doctor courtesy I am talking about. Now we have medical insurance, and physician insurance goes hand in hand with hospital insurance, so that doctors are paid for treating doctors, just like everybody else.

The money isn't all that important, and I am sorry to see professional courtesy go. It was our way of saying, you're a colleague, you're one of us, you may be in a strange city but we're both doctors; I wouldn't think of sending you a bill, and I know you won't charge me when you are the doctor and I am the patient.

That kind of courtesy went away with the beautiful M.D. insignia on the license plate, and *that* disappeared with the nurse's cape. Beards vanished (they are back now, but not for the same reason) and the little black bag is gone. I do not often see stethoscopes around doctors' necks, head mirrors are not plentiful, and I do not own a white coat, so I have no place for tongue depressors.

O for the good old days, but *these* are the good old days of twenty years from now. The license plate medal and the white coat do not bother me, but professional courtesy was different.

It was *personal*.

—F.C.

The Patient

Presentation at the Dedication of
the University of Nebraska Clinic
October 2, 1977

University of Nebraska Medical Center
Omaha, Nebraska

ROBERT D. SPARKS, M.D.

MY participation in this ceremony permits me to complete a cycle of guest to faculty member and administrator to guest again at the University of Nebraska Medical Center. As I arrived here in 1972, intense discussions were underway about plans for the facility being dedicated today. The changes which have occurred here in the last fifteen years have been exciting, responsive, and futuristic for education of health professionals in Nebraska. Everyone who has participated in the evolution of these new programs and the facilities to house them should have appropriate pride. Certainly I am immensely proud to have been a part of these events. I know you share that pride without apology. But the true significance of this day and this dedication can only be measured properly by the products of the days ahead. I choose to focus my comments today on one of the major beneficiaries of the University of Nebraska Clinic and its programs, the patient.

It was November 14, 1975, when Dr. Holman Wherritt, Regional Health Director for the Department of Health, Education and Welfare gave a convocation address noting the beginning of construction of this building.¹ In his comments he suggested that an important function of this facility could be to serve as a bridge between the Medical Center and the community. I agree this bridging is the most important of several functions because it will permit provision of medical care and health services to people as it fulfills its principal mission as a site for education of future health professionals. Everyone who seeks care in this facility should and will expect quality care and services, delivered in a manner fully considerate of the needs of that individual. In any institution the size of this medical center, discharge of that responsibility in

exactly that manner is easier described than carried out. I join Dr. Holman in his earlier urging that this facility and its programs serve as a bridge for patients, students and practitioners that form that community. The major challenge in completing that task will be to focus on what seems to be conflicting concerns for quality and costs of medical care and health services. This challenge will compose the excitement of the future of the programs in this Clinic. The opportunity for your successful efforts must not succumb to the despair and cynicism expressed in many places today about medical care.

A favorite essay for me is written by John Gardner and titled "Excellence — Can We Be Equal and Excellent Too?"² I quote it to draw from a broader social concern, the expression of challenge for the faculty on this campus for the programs that will be conducted by the University of Nebraska Clinic. In 1961, Gardner wrote: "Some of those who complain about the quality of our national life seem to be dreaming of a world in which everyone without exception has talent, taste, judgment, and an unswerving allegiance to excellence. Such dreams are pleasant but unprofitable. The problem is to achieve some measure of excellence in this society, with all its beloved and exasperating clutter, with all its exciting and debilitating confusion of standards, with all the stubborn problems that won't be solved and the equally stubborn ones that might be." He proceeds to say: "If a society holds conflicting views about excellence — or cannot rouse itself to the pursuit of excellence — the consequences will be felt in everything that it undertakes. The disease may not attack every organ, but the resulting debility will be felt in all parts of the system. Everything that it does and everything that it strives for will be affected." Excellence and its qualities may escape an exact definition when we

describe education and services of health professionals. But it is a commitment to the future which requires that we seek to present the best quality possible within the resources that can reasonably be made available. Excellence of care here must be perceived by the patients as understanding, available and comprehensive of the problems presented by the patient. Medical institutions with the awesome size of these buildings and this campus do intimidate any visitor on first entrance. Such intimidation only adds to the new patients' apprehension (if not stark fear) on entering these buildings for medical care. Every employee and student must strive to contribute to an excellence of understanding and humaneness by showing warmth and friendship to the bewildered public (and often the students) who seek to find their way through what is surely a maze of hallways and doors when viewed the first time. To strive for and speak of excellence within the programs of this new facility must not be offered with apology although that has too often been the circumstance across this country in the last 10-15 years. To strive for excellence or quality has been too often interpreted as haughty elitism to the point that I think we have shunned the use of the words in stating the goals and aspirations of institutions and individuals. Surely we wish to teach excellence and quality, and we should say so. These statements cannot be projected or interpreted in a contemptuous, self-serving manner such that they appear to imply that no where else can excellence be found. No task or setting is too menial or too isolated to escape the expectation of excellence, for each of us must seek that fulfillment if we are to achieve the potential that is here. Again, John Gardner says it well: "An excellent plumber is infinitely more admirable than an incompetent philosopher. The society which scorns excellence in plumbing because plumbing is a humble activity and tolerates shoddiness in philosophy because it is an exalted activity will have neither good plumbing nor good philosophy. Neither its pipes nor its theories will hold water."²

Those who will teach physicians, nurses, dentists, pharmacists, and a host of other

health professionals in this facility by examples of excellent medical care, do realize that the students of today will be the practitioners of their professions for the next 40 years. Students must learn the practices for medical care and health services as they are used today, but be prepared to accommodate the changes which will occur during the next four decades. Change is inevitable for the health practitioner. The only question is how much change will there be by the year 2017? I see little sign that science, as it relates to medicine, has slowed the pace exhibited in the 40 years since 1937. In these last 40 years medicine has benefited by the introduction of sulphonamides as antibiotics in 1938 and penicillin for similar purposes midway in World War II. Cortisone was introduced first for the treatment of arthritis and later to overcome extreme shock. Kidney transplantations began in 1950 and evoked a new science in tissue transplantation and tissue typing. The polio virus was isolated and vaccines prepared by 1955, which permitted the end of another dread disease of childhood. Open-heart operations and repair of large arteries have been possible since the early 1950's by use of artificial pumping of blood and exchanges of oxygen and carbon dioxide by the heart-lung machines.

How much could the students of 1937 have anticipated the technology that is available in 1977 for care in the intensive care units of our hospitals or the sharp reduction of the killer infectious diseases by the several antibiotics that would be introduced during their professional careers? What can the students of 1977 anticipate about the four decades that will span their careers of service? Certainly medicine will change dramatically. Who among these students will join the new space explorers and settlers that will succeed those who developed the West of our country? As preposterous as it may seem at this very moment, those who are students in the health professions today are very likely to have some of their classmates become a part of the first colonies in space. What new medical care will be required by exposure of these settlers to radiation and strange climates in artificial environments? How much will the space

technology which permits that colonization, contribute to new technology for application in our earthly hospitals and office practices? How will that technology produce new practices in medicine for inhabitants of the unearthly colonies? It is not too outlandish to think that the principles of present space-medicine should be understood by students in the programs that will be offered in this clinic and hospital and the hundreds of clinics of other teaching medical centers in this country. Think of the experience of settling the region of our country now called Nebraska. Lewis and Clark explored the area in their expedition of 1804-1806, under sponsorship of the United States Government. The explorers of Nebraska and its region "were unfavorably impressed with the area, and their reports gave rise to the belief that it was little more than a desert and entirely unfit for agriculture." But Bellevue, Nebraska, was founded in 1823, only 17 years later. And in the next 30 years Brownville, Nebraska City, Omaha, Plattsmouth, and Florence were established. By 1860, the state had a population of 28,841. It was 1867 when Nebraska was admitted to the union as the 37th state and began its contribution to the nation and world as an agricultural state, in spite of the dismal earlier reports about such prospects. In the 40-year period of 1806 to 1846, the land to be known as Nebraska, had been explored and settling begun. The first explorer to set foot on territory outside this earth did so on July 30, 1969. Our current pessimistic concept of the value of the moon's surface to man is not dissimilar to the early reports about Nebraska. How can we predict what man will do about exploration and settlement of the moon's surface or other space sites before the year 2017? I would venture the possibilities are overwhelming that man will be living in space before the current students at the University of Nebraska Medical Center have ended their productive professional years. What are the principles of medical care and health protection that these students should know that will be of value in caring for that generation of space settlers? Surely much of the knowledge will be the same as has been used for the last 40 years. But for these students the future is truly now. And the opportunity for medical care and education in this facility

is certainly to teach of medicine now but also to anticipate a future that will very likely generate a greater difference than has been medicine's change for the prior 40 years. The opportunities to benefit patients must be thrilling to contemplate.

But the realities of today will not escape us. No issue challenges medical care and health services more today than the frustration of their costs. Those who will provide care in this building must be prepared to confront the question of cost, not only of that care, but the costs of the education and research provided as well. This challenge must not be so frustrating that it overwhelms the prospects of excellence and quality in medical care, education, and research. My subsequent comments may challenge the concern for these costs but in no way do I intend to minimize the significance of the legitimate public concern about costs of medical care. Those who must enter the debate on costs of medical care must consider the subject with a reasoned, comprehensive statement of such costs. To proclaim with horror that the expenditures for medical care and health services in the United States are $3\frac{1}{2}$ times greater in 1976 than they were in 1966, and 16% greater in 1976 than they were in just the year before, may seem appropriate but is unproductive pragmatically. Inflation in 1976 was nearly 6%, leaving 10% to be described. What role did the introduction of new technology play in the remaining 10 percentage points of increase? Do we want that new technology? What role did payment for services previously unpaid (such as for the elderly or dependent individuals), play in the increase of expenditures? Does this society understand that Medicare and Medicaid now pays for services which are therefore counted in the expenditures column whereas the same services ten years before may have been provided but without payment for the care and thus not have been counted in the dollars expended for medical care and health services? Does this society want to improve access to medical care by eliminating economic barriers to care, whatever those costs are? Is it understood that our present governmental and private medical insurance and personal payments for care will surely

drive the expenditures for medical care beyond the rate of inflation even if we could stop new technology? As we enter the years beyond age 65, we use nearly 3 times the medical services as we did when we were younger. In 1970, there were about 21 million Americans over the age of 65; by 1976 there were nearly 23 million Americans over 65. That is a 9% increase of our elderly population, a group which will need medical services at a much greater rate than any other age group. And the elderly now generally have financial provisions for the costs of their medical care, which was not true prior to 10 years ago. By the time the current students of this Medical Center join the ranks of the elderly, in 2017, the number of our people over age 65 will probably exceed 40 million. The implications for the provision of medical care due to this single change in our population is profound for the tally of expenditures for medical care and for the character and amount of services which will be required. These are but a few of the many contributions to the total dollars expended for medical care. My listing is not intended to be complete nor to be misleading. Before we as patients are stampeded into responses to the rapidly increasing expenditures for medical care and health services, we deserve and will probably demand, fairer treatment in the quality and comprehensiveness of the data by which we are now overwhelmed. The professional staff of the University of Nebraska Clinic must respond to these questions of costs of or charges for medical care by institutions and professionals in such a way that the patient, the public, and the students will understand them. The issue is not unique to the University of Nebraska Medical Center, obviously. But the health professions cannot evade their responsibility to respond to their patients and the public on the question of costs of care and services. Nor do I think they will or want to ignore what is surely a complicated discussion and understanding. The students of today will be expected to respond to such questions in the future. The

quicker a plan is evolved for presentation of simplified but representative data on costs, the quicker the providers of medical care will be able to resume greater dedication of their efforts to provide professional services and education, and not be involved in street corner and television histrionics about such costs.

I have little time for public leaders who are doomsayers and cynics, who only pose questions but have no reasoned, pragmatic alternatives in response. I am optimistic about prospects for the programs which will be offered in this Clinic to the great benefit of people known here as patients — and students. The opportunities for new frontiers in our society generally and for medicine specifically, are exciting. But I caution that the ultimate benefits must accumulate to the patient as we seek excellence in offering education, research, and services, and confront the reality of the costs of these activities. The value must be understood and must be palpably beneficial as perceived by the patient. The satisfactory encounter of the patient with this magnificent resource of facilities, professionals, employees, and students must be a concern to everyone who can be of help to that patient. To fail in this goal will not be simply to have disappointed that patient today but to have failed medical care and health services into the next century. The history of all the health professions assures me that the University of Nebraska Clinic and the opportunity that it provides, will meet the challenge to the benefit of its patients, both those here now, and those who will be served by the graduates in the future, wherever that might be in this galaxy.

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A Follow-up Study of Nebraska Medical School Graduates During Their First Year of Residency

EACH year approximately 145 students receive their medical degrees from the University of Nebraska College of Medicine. For most students three to five years of additional education lie ahead. Consequently, one concern of medical schools is that the undergraduate medical curriculum should adequately prepare their graduates for residency training. Few studies, however, have specifically examined this implicit concern.^{1, 2}

To ensure that medical graduates have received a quality education and possess the necessary skills, a number of evaluative mechanisms have been incorporated into the educational process at the University of Nebraska College of Medicine under the auspices of the Curriculum and Scholastic Evaluation Committees and through the assistance of the Office of Educational Research. These committees monitor and assess the skills and knowledge of students and the quality of programs, courses, and instruction. In a recent recommendation that the University of Nebraska Medical Center's accreditation be renewed for ten years, the North Central Association of Colleges and Schools reported that the Medical Center is doing well in all its academic programs and that "students, regardless of their college, were pleased with their educational experiences . . . and thought their faculty to be competent."

Despite these positive pronouncements and other supporting data, additional information is needed to assess more thoroughly the adequacy of the undergraduate medical curriculum as preparation for residency training. The purpose of this study is to provide such information through an assessment of the performance of Nebraska Medical School graduates during their first year of residency, and through residents' evaluation of the adequacy of their undergraduate medical education.

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METHOD

Nine months after beginning the first year of residency, a questionnaire was mailed to a recent graduating class of the University of Nebraska College of Medicine and to their respective residency supervisors throughout the country. Approximately 75 percent of the sample returned the questionnaires. Supervisors judged the performance of residents using a 25-item questionnaire consisting of the following five scales which were suggested and condensed from the major content areas of National Boards Part III: 1) History and Physical, 2) Diagnostic Procedures, 3) Diagnostic Acumen, 4) Treatment, and 5) Continuing Care.³ For the same 25 competency items, residents independently assessed how adequately their undergraduate medical education at the University of Nebraska had prepared them for the first year of residency. All ratings were made on a 12-point scale. The residency-supervisor scale ranged from Truly Superior to Definitely Below Average. The resident scale ranged from Exceptionally Well Prepared to Very Poorly Prepared.

RESULTS

Factor analysis indicated that the 25 items used in assessing residents' perceptions of their undergraduate medical education could best be summarized by partitioning these items into five separate scales. These scales coincided, in large part, with the major content areas of National Boards, Part III. The mean ratings for all five scales are presented below in Table 1.

TABLE 1
RESIDENT ASSESSMENTS OF
UNDERGRADUATE CURRICULUM

Scale	Mean
History and Physical	9.46
Diagnostic Procedures	9.03
Diagnostic Acumen	9.20
Treatment	8.75
Continuing Care	8.05

It is evident from Table 1 that the residents judged they were adequately prepared for their first year of residency. Thus, despite minor differences between the average ratings on the five scales, there were no educational deficiencies in any of the five areas.

Residents were also asked to respond to the following general item: "My undergraduate medical training provided a sound educational base upon which to begin residency/internship training." Residents responded on a 5-point scale ranging from strongly agree to strongly disagree. The

mean assessment made by residents on this item was 4.06, indicating that residents generally agreed that they had begun their residency with a sound educational base.

Using the same 25 competency items, factor analysis indicated that supervisor ratings of the performance of residents could best be represented by an overall score on the 25 items. The mean overall score on a 12-point scale, was 9.07. In other words, in comparison to other residents observed by these supervisors, the performance of Nebraska graduates was above average.

DISCUSSION

The results of this study indicated that the University of Nebraska College of Medicine graduates were adequately prepared for their first year of residency. This was evidenced both by residents' assessment of their undergraduate medical education and by supervisor's ratings of their actual performance. Most importantly, ratings by both residents and supervisors were generally quite positive.

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Cranial Computerized Tomography and Chronic Multiple Sclerosis

ABSTRACT

The cranial computerized tomography appearance of long standing cases of multiple sclerosis is one of atrophy with compensatory enlargement of ventricles, fissures, cisterns, and sulci.

JOHN F. AITA, M.D.*

THE cranial computerized tomography (CT) appearance of multiple sclerosis is well established and is related to the size, location, and age of the demyelinating process.¹

In chronic cases of multiple sclerosis, cranial CT demonstrates atrophy which is characterized by enlargement of ventricles,

fissures, cisterns and sulci.²⁻¹⁰ Neuropathologically, this atrophy seen in long standing cases of multiple sclerosis is felt to be due to shrinkage of the white matter secondary to both sclerosis and tissue loss from demyelination.¹¹⁻¹³

Figure 1 is representative of the cranial CT appearance of chronic multiple sclerosis.

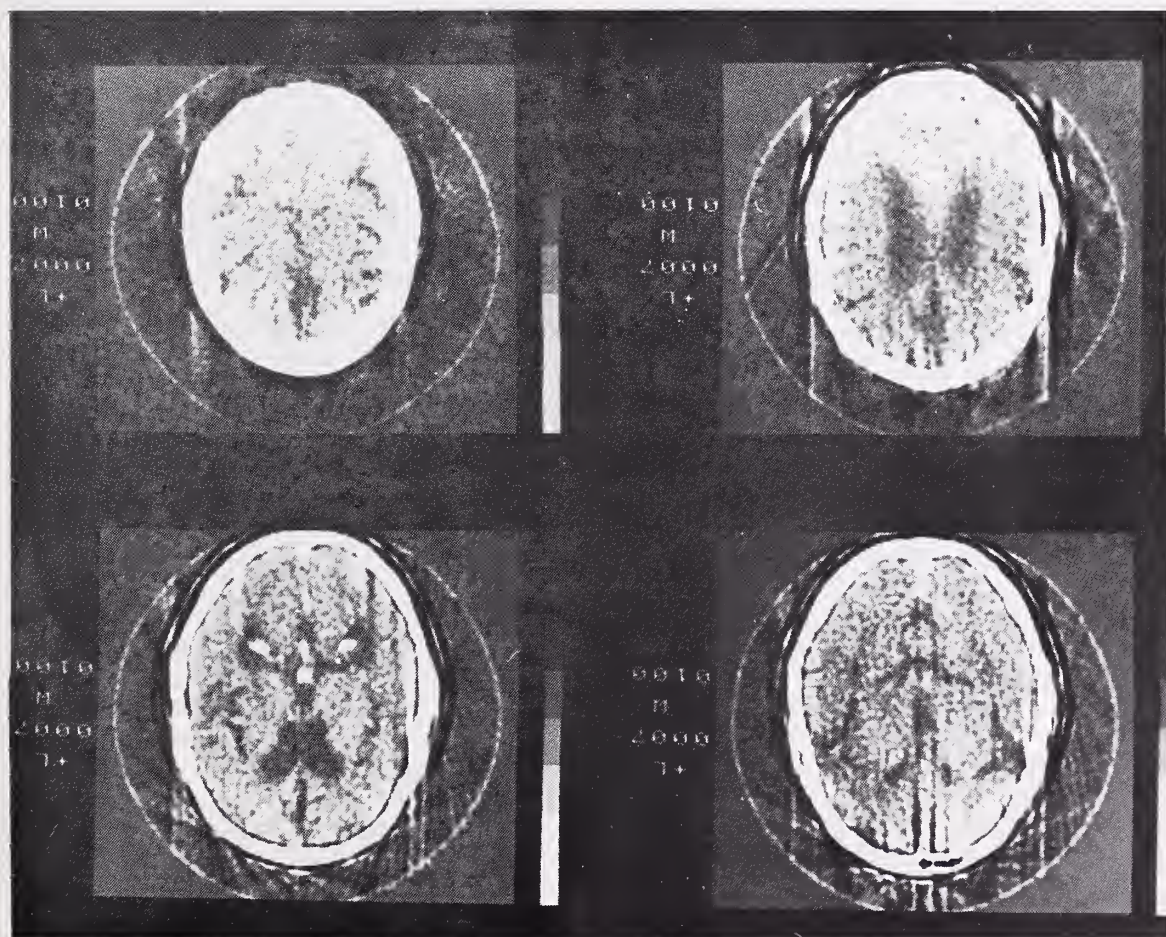


Figure 1

45 year old male with documented multiple sclerosis of 18.5 years duration. Cranial CT evidence of diffuse atrophy with enlargement of both lateral ventricles, third ventricle, right and left Sylvian and anterior inter-hemispheric fissures, cisterna ambiens, and sulci.

bably regions of sclerosis ¹⁴); of this group, 40 patients (98%) also had cranial CT evidence of atrophy.

Thus, cranial CT may be of value in the diagnosis of long standing cases of multiple sclerosis by demonstrating generalized atrophy with enlargement of cisterns, fissures, sulci, and of the ventricular system. The patient, a 45 year old male with well documented multiple sclerosis of 18.5 years

duration is shown to have diffuse atrophy with enlargement of right and left lateral and third ventricles, right and left Sylvian and interhemispheric fissures, cisterna ambiens, and sulci. The generalized atrophy seen in this case is almost identical to that seen in a 70 year old female with dementia secondary to a diffuse atrophic-degenerative central nervous system disease process. (Figure 2).

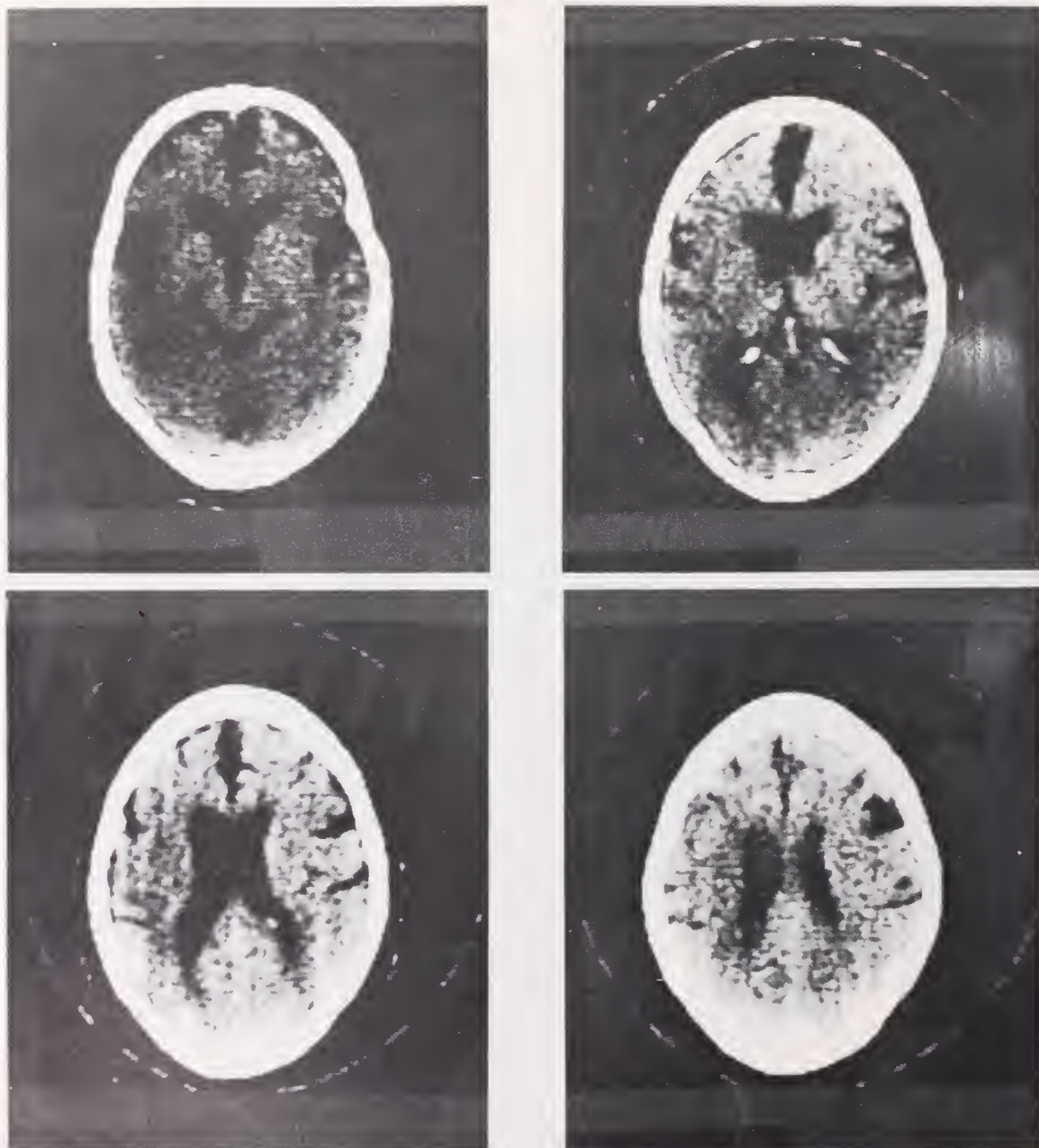


Figure 2

70 year old female with dementia. Cranial CT evidence of diffuse atrophy with enlargement of both lateral ventricles, third ventricle, right and left Sylvian and anterior interhemispheric fissures, cisterna ambiens, and sulci. [Reprinted with permission of the Nebraska Medical Journal].

Gyldensted^{6,7} studied 110 multiple sclerosis patients with cranial CT and found that 86 patients (78%) had evidence of atrophy with an increase in the size of the sulci, Sylvian fissures, and lateral, but not third, ventricles. Fifty of these 110 patients (45%), with an average duration of multiple sclerosis of 18.4-19.0 years, were found to have atrophy only — similar to the case represented in figure 1. Forty-one of his 110 patients (37%) were found to have periventricular low x-ray attenuation areas (pro-

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Damaging Effects of Sunlight on Human Skin

WITH apparent disregard for the efforts of this country's cancer societies and dermatologists, most Americans still equate a summer tan with attractiveness and health. Unfortunately, medical data point to the conclusion that long term indiscriminate exposure to sunlight is a cause of premature aging of the skin and of neoplasms. New evidence suggesting a causal relationship between sun exposure and lethal malignant melanoma is even more distressing. Protective measures and moderation must be advised for patients who insist on sunbathing.

Sunburn

The series of physical and photobiological events responsible for sunburn is complex. Of the total radiation produced by the sun,

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composed of wavelengths ranging from very short x-rays to the very long low-energy radiowaves, less than 0.2% reaches the earth's surface within the spectrum which causes sunburn.¹ In the outer atmosphere, wavelengths shorter than 240 nm convert oxygen (O₂) into ozone (O₃) which in turn

effectively absorbs all other wavelengths shorter than 290 nm.² Of the remaining ultra-violet wavelengths up to 400 nm at the edge of visible light, those between 290 and 320 nm represent the erythrogenic or sunburn spectrum.³ This range is also known as UVB, while wavelengths from 320 to 400 nm are referred to as UVA (Figure 1). These longer wavelengths cause no adverse changes in the skin when acting alone, but probably augment damage caused by those in the 290-320 nm range.⁴ Once light energy of the appropriate wavelengths strikes unprotected, lightly pigmented skin, a cascade of photobiological events starts into motion. The electrons of organic molecules within the skin are excited from the ground state into a singlet or triplet state by the absorption of a photon.⁵ The decay of these excited states provides energy, inducing chemical reactions within the biomolecule, most of which result in damaging alterations. A system of poorly recognized mediators, some of which are probably prostaglandins,⁶ is also activated with the end result being inflammation.

Incident sunlight to the earth's surface has the greatest proportion of wavelengths within the erythrogenic spectrum during the hours when the rays travel the shortest distance through the atmosphere: during the summer, usually between 10 A.M. and 2 P.M. Factors which are in direct proportion to the potential for sunburn include heat,⁷ wind,⁸ and humidity.⁹ Fairly complected individuals who do not enjoy the photoprotection of large amounts of melanin in their skin are of course at greater risk.

In most instances cutaneous inflammation presents as the familiar tender redness of sunburn, usually abating in 24 to 48 hours and leaving in its wake a mildly protective tan. More severe reactions often lead to vesicle and bullae formation followed by epithelial sloughing. Systemic symptoms of toxicity such as fever, chills, nausea, and prostration¹⁰ may be seen with extreme overexposure. Occlusive ointments such as petrolatum which increase epidermal hydration are adequate for mild cases, while topical corticosteroids may be necessary for more severe burns. Short-course systemic steroids are justified in very serious reactions¹¹ and when extensive bullae forma-

tion is present. Topically applied prostaglandin inhibitors such as indomethacin¹² hold promise, but are not yet accepted for general use.

Aging

While most of us are resigned to the inevitability of aging, unresolved fears of growing old are often centered on one organ — the skin. Regardless of the state of one's liver or kidneys, a person is judged to be young or old for his age depending primarily on the state of preservation of his skin. Most persons are more fearful of the cosmetic afflictions associated with aging such as wrinkles, mottling, discoloration, atrophy, and keratoses than they are of actual skin cancer. In fair-skinned whites, sunlight is far more important than time in bringing about these changes.¹³

The suggestion that sunlight exposure over a number of years causes damage to the skin far out of proportion to time has been confirmed both by simple observations and detailed histopathologic and biochemical studies.¹⁴ Although clinically obvious degenerative changes rarely appear before age 50 in the general population,¹⁵ people with a long history of chronic sun exposure such as sailors and farmers often show evidence of irreversible solar injury at a much younger age. Moreover, damage of this type is limited to those areas that are generally unprotected such as the forearms and the posterior portion of the neck, while over the remainder of the skin the clinical age appears consistent with the chronological age.

Well-constructed investigations have substantiated the clinical impression that exposure to sunlight contributes to premature aging of the skin. Kligman compared histologic evidence of degeneration as evidenced by elastic tissue changes in biopsies taken from the cheek and buttocks.¹³ While most persons beyond the fourth decade showed serious elastic-tissue abnormalities in skin taken from the malar eminence, the unexposed skin of the buttock exhibited only a slight increase in elastic fibers even in old age. In other studies, the activity of nine metabolic enzymes within the skin was found to be significantly decreased proportional to age in exposed skin of the dorsal hand, but

essentially identical in relatively unexposed skin of the abdomen taken from volunteers ranging in age from nine months to 90 years.^{16, 17} Reduced activity of these important enzymes may explain in part the diminished ability of chronically exposed skin to regenerate and the tendency of the epidermis toward general thinning and atrophy.¹⁸

Malignancy

The fact that long-term sun exposure is a primary predisposing determinant in the pathogenesis of skin cancer is well documented. Basal cell carcinomas, squamous cell carcinomas, and premalignant actinic keratoses are all neoplasms of epithelial origin which are formed by the dysplastic proliferation of keratinocytes in response to chronic solar stimulation.¹⁴ Of more recent concern, however, is the establishment of an association between sunlight and malignant melanomas which, unlike basal cell carcinomas, are not always localized and readily curable.

The incidence of premalignant actinic keratoses in a white population predominantly engaged in farming was found in one study to be 16.3%, while the rate of basal cell carcinomas in the same group was 4.4%.¹⁹ All of these were found on parts of the body relatively unprotected from ultraviolet rays. Fortunately, neoplasms of this type are easily accessible and can be successfully eradicated if brought to medical attention early in their evolution. Keratoses will respond to electrodesiccation, cryotherapy, and topical 5-fluorouracil. A variety of modalities may be employed for the destruction of basal and squamous cell carcinomas, including radiotherapy, thermocouple, chemotherapy, excision, and electrofulguration with curettage. The latter method is favored by dermatologists because of cosmetic results and a 95% cure rate.²⁰

In contrast to the above mentioned neoplasms which can be successfully treated in the physician's office, most melanomas at some time require the diagnostic or therapeutic capabilities of a hospital setting. Melanomas are thus more likely to be included in tumor registries which are heavily dependent on hospital records, and

incidence rates are more reliable. Demographic studies using these incidence rates have implicated the cumulative influence of sun exposure as a causative factor in the formation of melanomas.²¹ Data show an increase in melanomas as latitudes decrease, i.e., approach the equator,²² and also an increase directly proportional to the length of time individual members of a population have lived in a sunny climate.²³ The fact that there is a relatively higher incidence of melanoma among females, especially on areas where there is preferential exposure such as the lower leg²⁴ also points to the augmentative role of ultraviolet rays and emphasizes the importance of protective measures.

Protection

No wide-range educational program sponsored by the medical profession will dissuade people from striving toward their time-honored objective of a summer tan.

Because of the fact that the ultraviolet spectrum can be separated into those wavelengths which produce sunburn and degenerative damage (290-320 nm) and those which stimulate tanning while causing no apparent adverse clinical or histologic change (320-400),⁴ protective measures are available to alleviate the former and augment the latter. For example, a simple pane of window glass will effectively block the rays of the sunburn spectrum, transmitting the longer UVA rays which initiate pigment darkening.²⁵ Another simple solution is the avoidance of sunlight during the hours on either side of noon when the rays within the spectrum are more intense, concentrating instead on exposure in the later afternoon.

For those who wish to continue basking in direct mid-day sun at the side of a pool, a pragmatic solution is the application of one of the new sun screens which contain para-aminobenzoic acid (PABA) or one of its esters. Following studies performed from 1966 to 1968 using volunteers at the Arizona State Prison, Pathak et al reported the effectiveness of these preparations in providing protection against sunburn while only partially inhibiting tanning.²⁶ Subsequent studies confirmed that alcoholic solutions of PABA were more effective than other

available sunscreens including the PABA ester in shielding the skin from ultraviolet radiation within the erythrogenic spectrum.²⁷ It was also shown that PABA alcohol solutions offered residual protection after immersion, if present on the skin 2 hours before entering the water.²⁸

Other topical preparations afford varying degrees of protection ranging from the total blocking effect of zinc oxide and red veterinary petrolatum to the purely moisturizing effect of baby oil. None, however, have PABA's combined advantages of preferentially screening damaging wavelengths from the sun while at the same time allowing the pigment stimulating rays to pass through.

Many dermatologists suggest that patients with naturally dark skin coloration, as well as those who have attained a degree of protective tanning, need religiously use sun screens only on facial skin, since this is the area of prime concern when considering the destructive long term effects of the erythrogenic spectrum. If sufficient care is taken in the implementation of these types of preventative measures, exposure to warm sunlight can be enjoyed without inviting the depressing eventuality of disfiguring visible neoplasms and premature cutaneous age.

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Reflections: Sixty Years of The University of Nebraska Hospital and Clinics — April, 1977

ORIGINS

AS early as 1869, physicians in Omaha with an interest in medical education assembled to discuss the creation of a medical college. This group was led by H. P. Matthewson, M.D., who expressed the opinion that the building of a hospital and medical college should proceed hand-in-hand. After years of planning, the efforts of this group failed to take hold, and they dissolved their affairs in May, 1881.

At about the same time, the "Nebraska School of Medicine, Preparatory" was offering course work in medical education and several physicians from Dr. Matthewson's group served on the faculty. From their initiative, the Omaha Medical College was founded in June, 1881, and facilities were

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Former Administrator
The University of Nebraska
Hospital & Clinics

constructed for the College in September of that year. In October, 1881, the Board of Trustees of the College agreed to receive,

"the small house owned by Mr. Creighton immediately west of the College, for hospital purposes, on the terms proposed that they furnish the building; nursing and feeding to be done by the Sisters; we to furnish a student as night nurse with the consideration that he take care of the property; they to furnish him with board



OMAHA MEDICAL COLLEGE 1881
(Small bldg. was used for hospital purpose)

and lodging; with the understanding that as soon as the new hospital building is completed, we as a faculty shall have entire control of the medical and surgical departments of the same . . .”¹

The Omaha Medical College remained a private venture until July, 1902, when the Board of the College entered into an agreement with the University of Nebraska and thereby became the College of Medicine of the University of Nebraska.

FACILITIES

The College of Medicine affiliated with hospitals in the Omaha area and maintained a dispensary (i.e., outpatient clinic) to provide clinical education for medical students.

By 1915, the University and the Legislature agreed to commit funds for the construction of a University Hospital at the site of the College of Medicine in Omaha.

The University Hospital was dedicated on September 3, 1917. The purpose of the Hospital was set forth by the Board of Regents of the University of Nebraska:

“The Hospital for the University of Nebraska at Omaha is not founded with the idea of receiving patients who are able to pay for special medical and surgical care. Worthy sick, except as hereinafter specified, shall be admitted upon receipt by the hospital authorities of a written application, stating that the patient needs medical



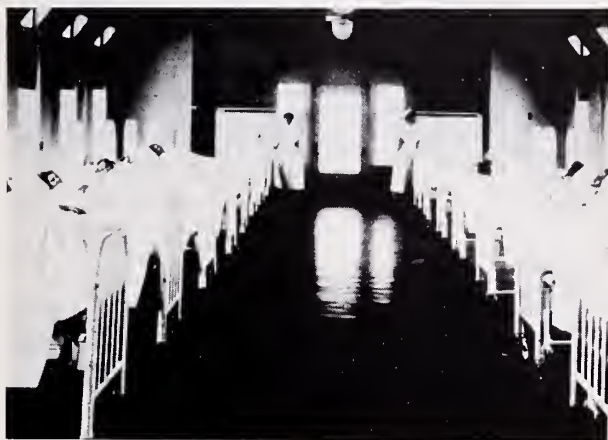
UNIVERSITY OF NEBRASKA
COLLEGE OF MEDICINE
CAMPUS, 1927



UNIVERSITY HOSPITAL
UNITS I & II, 1927

or surgical attention, and that he is unable to pay for professional services at the hospital."²

The original building (Unit I) consisted of 130 beds and was constructed at a cost of \$150,000. The medical staff of the hospital included 48 faculty members of the College of Medicine, all of whom were part-time.³



INPATIENT WARD
1917

Expansion of the Hospital (Unit II) was completed in 1927 at a cost of approximately \$200,000, increasing the capacity of the institution at that time to 250 beds. An interesting anecdote concerning the expansion was revealed in a letter from a graduate of the College of Medicine,

"The second unit of the hospital was under construction during the time that I was serving as the first resident in Pathology there. When a legislative committee visited the institution during the construction, it seemed imperative that all the beds in the first unit should be occupied so as to make the necessity of the new wing very obvious. As a result, some of the empty beds were soon filled with interns or student nurses."⁴

Whether this mischief was the cause has not been determined, but following completion of the project, the new facilities remained unused for a brief period as there were no funds appropriated by the Legislature for operation of the unit.

The depression of the 30s and obligations of World War II created hardships for the

maintenance and development of the Hospital, and no significant renovations took place during the next two decades. In 1962, Unit III, which included a 150 bed hospital, clinics, surgical areas, library and auditorium, was added at a cost of approximately \$2,600,000. In 1966, major remodeling of the inpatient ward areas was completed, and in 1969, Unit IV, consisting of new clinic facilities, laboratory and radiology services, was completed at a cost of \$6,984,987. In 1972 further remodeling took place.

In May, 1975, the Lions Eye Institute was dedicated. This addition provided outstanding facilities for patient care and research activities related to diseases of the eye, and was made possible by the financial support of the Lions Clubs of Nebraska. The Institute cost \$500,000, with half the funding provided by Lions Clubs from every county in the state.

Most recently, an "Ambulatorium" has been completed. This five-story ambulatory care building includes underground parking for patients and visitors, expansion of clinical offices, examination rooms, as well as additional laboratory and diagnostic radiology facilities.

Today, the University of Nebraska Hospital and Clinics includes 320 acute care beds, 52 ambulatory care beds, and 52 bassinets. The equipment and buildings represent over \$24,950,000 in assets, and the physical complex over 426,200 gross square feet.

FINANCES

J. Jay Keegan, M.D., Dean of the College of Medicine from 1925-1929, reported in November, 1927,

"The cost of maintaining patients at the University Hospital is between \$3 and \$4 per day, depending upon the separation of medical college expense from hospital maintenance. Patients who receive this excellent service at the University Hospital, which includes detailed case studies, with consultation and treatment by the foremost physicians of Omaha, are expected to pay at least cost of board and nursing, which is \$3 per day."⁵

Through the years, the question of legisla-

tive funding for support of the operation of the Hospital has remained a significant issue. In the past ten years, the financial position of the Hospital and Clinics has shifted dramatically toward self-support. In 1966, approximately 80% of the costs of operating the Hospital and Clinics was supported by legislative appropriation, and 20% by revenue from patient charges. By 1976, 85% of the cost was covered by revenue from patient charges, and 15% from legislative appropriation.

FUTURE STATUS

Today, the mission of the Hospital and Clinics differs from the original precepts set forth by the Board of Regents. There are no limitations, conditions or special requirements of patients who seek care at the University Hospital, and the growing demand for services reflects recognition of the Hospital and Clinics as a state-wide health care resource. The clinical programs of the Hospital and Clinics offer a range of preventive, diagnostic, acute, and rehabilitative services. The medical staff includes 120 full-time clinicians, representing most medical and surgical specialties. In addition to the full-time staff, many physicians from the area serve as volunteer faculty of the College of Medicine and hold appointments as active, associate, or consultant members of the medical staff of the Hospital and Clinics.

Effective community involvement in the



UNIVERSITY HOSPITAL
1975

affairs of the hospital and clinics is important in meeting public expectations, and cooperative planning with other health care providers.

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Down Memory Lane

1. The general practitioner's work has gradually become circumscribed by the inroads of specialism.

2. One of my very good friends and colleagues who has recently returned from Europe, was telling me of the humble surroundings in which some of the world's greatest medical men are found there. He compared that with the "showroom" tendency of the medical offices in this country, which are by-words of expensive furnishing and equipment in the rest of the world.

3. The demand for information on matters pertaining to health far exceeded expectation at the State Fair in September. A corps of four physicians was kept busy daily answering questions on hygiene, sanitation, and personal health.

4. The subject of thoracoplasty is one that is more or less new to American medicine.

5. That there is some want of understanding today between our profession and the public it undertakes to serve wants not witnesses: if one need evidence beyond his

immediate personal experience he may turn to the standard magazines for the layman's view point and to the responsible statements and efforts of the American Medical Association for the doctors. Briefly the feelings of the two sides, so far as the debate touches economic matters comes roughly to this, the patient is overcharged, the physician is under-remunerated.

The low average annual income of practitioners at large substantially less than \$4,000.00 would seem to afford *prima facie* evidence of the doctor's contention.

6. I believe there is room for more discussion on the paper.

7. In Nebraska there is no provision in law for the transportation of the patient to the University hospital, or for the payment of an attendant, while the Iowa law provides a fund disbursed from the state treasury for transportation, pay for an attendant and for hospital expenses.

Nebraska State Medical Journal
October, 1928.

In Memoriam

*By medicine life may be prolong'd
yet death*

Will seize the doctor too.

—Shakespeare

DR. GEORGE J. HASLAM

Doctor George J. Haslam died on April 21, 1978, at the age of 52. Doctor Haslam was born in Philadelphia, Pennsylvania, on April 27, 1925.

He graduated from the University of Nebraska College of Medicine in 1952.

Following an internship at Philadelphia General Hospital and a residency at Bishop Clarkson Memorial Hospital, he served on the Clarkson Hospital Pathology Department staff. In 1964, he moved to North Platte and founded Pathology Services.

Survivors include his wife Margaret; a son, George of Kearney; a daughter, Mrs. D. L. (Peggy) Ewing of North Platte; his parents, Doctor and Mrs. George A. Haslam, a brother, John A., and a sister, Mrs. David (Florence) Shelso, all of Fremont; two nieces, two nephews and two grandchildren.

President's Page

Justice Frankfurter could have been speaking of sociologists, bureaucrats, and a few other assorted folk when he said, "Experience passes through him without leaving a mark."

Some months ago there appeared in the Federal Register, that formidable instrument of federal bureaucracy, a notice modifying the criteria of shortage area for primary care practitioners. Whereas previously a shortage of such individuals was held to exist when their numbers reached a level of one practitioner per four thousand persons within the population, it was not ordained that the shortage would exist unless the ratio rose to 1 practitioner per 35 hundred people. There were other aspects of the proclamation having to do with the travel distance required to reach a practitioner, or the elapsed time from starting point to locus of potential therapy. Three terrain categories (normal with primary roads, mountainous with secondary roads, flat terrain or areas blessed with interstate highways), variations in population by seasons, by tourists and other migrant travelers, and adjustments for differing health requirements by various age, sex population groups. Physician to population ratio as a measure of adequacy or inadequacy of medical care, has been discredited so many times that it is scarcely necessary to add another lash to what should now be a thoroughly dead horse. The flogging of this particular beast appears to have declined since the planners decided that we are no longer short of physicians. Now we see that their fiats apply to the categories of physicians and to their distribution in the country. We have, it is said, too many specialists, and they are maldistributed, so we must cut back on specialists, redistribute them to "underserved" or shortage areas, and simultaneously produce more generalists.

Note that the primary medical care manpower used in these criteria includes nurse practitioners and physicians assistants as well as primary care physicians. In mid-May the Institute of Medicine released a 106 page document entitled "A Man Power Policy for



Primary Health Care." Fourteen pages were spent in an attempt to define primary care.

What is interesting in the new IOM study in contrast to the monumental obfuscation of the Federal Registry is the naive statement by which the "need" for a rise from the original arbitrary 50 percent proportion of residents in primary care training has been raised to 60 to 70 percent. Such numerical evidence has not been well developed and one is not surprised by the turgidity and the silliness of the Federal Register item. But we would have expected better from "distinguished members of appropriate professions . . . enlisted . . . in the examination of policy matters pertaining to the health of the public." The common denominator of these two statements on shortages and percentages is an arbitrary, arrogant statement of a goal, supported by nothing but preconceptions or the flimsiest kind of evidence.

This exercise brings to mind the three least creditable sayings —

1. Your check is in the mail,
2. Of course I'll respect you in the morning, and
3. I'm from the government and I'm here to help you.

Houtz G. Steenburg, M.D.



The Auxiliary

In May, 1978, I represented your Nebraska Auxiliary at Minnesota's Golden Anniversary Safety Meeting. It was their opportunity to recognize outstanding organizations and individuals. Attractive booths indicated where one can obtain supplies. Movies and inspirational speakers gave motivation. Small meeting allowed individuals to participate.

Car Accidents

The meetings were especially interesting in relationship to the causes of automobile accidents. This included discussions of the importance of the 55 miles per hour speed limit.

When a driver feels harrassed by traffice, it is probably because he or she is suffering from worry, fatigue, and pressures from hate, anger, or illness. It has been shown that tension and irritability premenstrually result in loss of judgment and in slower reactions. Those women who have borne children tend to be accident prone both premenstrually and during the menses. On the other hand, those who have never borne children seem to be accident prone only during the premenstrual days.

Other strains affecting driving include financial worries, squabbles at home, a child's difficulties at school, a too heavy schedule, and exhaustion. Most accidents happen because the driver is not feeling up to par physically or emotionally.

If you are tired, angry, or ill and you must travel:

1. Don't drive during the rush hour.
2. Wait until you feel better.
3. Make the trip brief.
4. Call a taxi.

Smoking

One of the pulmonary physicians and others working with respiratory problems in Omaha developed the idea of having unusual posters and table signs for educating the public about the dangers of smoking. These can be changed each month.

The American Lung Association of Nebraska has given \$1000 toward the expense of printing twelve different posters by an Omaha cartoonist. Five hundred complete sets of posters were printed and mailed in groups of three to Nebraska hospitals and other health-related institutions. The total cost was \$2000.

The national office of the American Lung Association liked the set of posters they received. They selected three for nationwide distribution to affiliated local societies. 25,000 copies of each poster were printed.

The greatest single group of new smokers comes from the female population under 21 years of age. It is especially important to reach this group.

Some statistics:

1. It costs \$10 per month for the average smoker who purchases 15 packs per month.
2. Mothers-to-be who smoke have a two-fold increase in miscarriages.
3. Emphysema is 19 times more common in smokers than in nonsmokers.
4. Heavy smokers have a two to three times greater chance of dying of a heart attack than nonsmokers.
5. Cancers more common among smokers include those of the mouth, lips, larynx, pancreas, and urinary bladder.

Eleanore M. Ward
Omaha

HEALTH GALLERIES DONOR LIST

Recognition is given to individual and medical organizations as follows:

BENEFACTORS (name on specific exhibit)	\$5,000-\$25,000
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+SPONSORS (certificate of appreciation)	200- 999
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Total cost of the Health Galleries Project \$500,000.00
Goal for support from Medical Community 150,000.00*
*House of Delegate action October 1976, recommended
that each physician donate \$200.00 over a three year
period.

70% of the \$150,000.00 has been raised
through contributions made by physicians
listed in the Nebraska Medical Journal. All
monies raised will be used for the develop-
ment of the exhibits in the galleries.

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Health Galleries

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University of Nebraska
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Health Galleries

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Have You Made Your pledge to The Health Galleries?

70% of the medical community goal of \$150,000.00 to the Health Galleries has been raised!! Use the form below! **SEND YOUR PLEDGE TODAY!** (All donors from the medical community are listed in the monthly issues of the **Nebraska Medical Journal.**)

University of Nebraska
State Museum



Health Galleries

In accordance with the House of Delegates action* we give/pledge \$_____ for the development and maintenance of the Health Galleries.

Make your check payable to: The University of Nebraska Foundation

Mail to: NU Foundation, P.O. Box 30186, Lincoln, NE 68588

Name: _____

Address: _____

County Medical Society _____

For my pledge please send reminders _____ Annually _____ Semi-annually _____ Quarterly

★ October, 1976 Resolution for gift from each physician for \$200 to support the Health Galleries.

Between Cases

Words I Can Do Without.

Caveat, speciality, pristine, tenuity, affordable, if you will.

Advice To An Intern.

Try not to cut yourself.

From: The doctor game; by H. Olgin.

Definitions.

Hope: a pathological belief in the occurrence of the impossible.

Mencken.

Quote Unquote.

My heart is quite normal. I'll stake my life on that.

From Cardula and the kleptomaniac; by J. Ritchie.

Heard On TV.

Economically-wise, ten minutes in front of the hour.

Section On Longevity.

We could live almost forever if we had enough courage. It's of our lives that we die.

On the gull's road; by Willa Cather.

On The Pill The IUD Et Al.

Birth control usually meant no birth and no control.

From Bless me, Father, by Neil Boyd.

Department Of Pollution, Some Years Ago.

I was singularly struck, some years ago, by finding all the river shore at Richmond, in Yorkshire, black in its earth, from the mere drift of soot-laden air from places many miles away.

Ruskin: Sesame and lillies.

O to be in England.

On Healing.

Cuts, bruises, infection, disease, shock, sorrow — the body grasped them all at once and forever. The body had its own insight, its own learning. In its own way the body knew what happened and what to make of it.

Elizabeth Cullinan: The sum and substance.

In 17 Words.

Members of the medical profession have often been unscrupulous and piratical jargonists with other men's jargon themselves.

Philip Howard: New words for old.

Section On Culture.

... for those who ... intend to follow the profession of medicine ... in my opinion, classical education is a mistake ...

Huxley: Science and culture.

—F.C.

Welcome New Members

David R. Colan, M.D.

729 North Custer

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James D. Emery, M.D.

1315 Tibbals

Holdrege, Nebraska 68949

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805 South "F" Street

Broken Bow, Nebraska 68822

Steven L. Husen, M.D.

711 West Anna

Grand Island, Nebraska 68801

Mark E. Janulewicz, M.D.

Box 1548

Grand Island, Nebraska 68801

Roger N. Ruckman, M.D.

Department of Pediatric Cardiology

University of Nebraska Medical Center

42nd and Dewey Avenue

Omaha, Nebraska 68105

Michael L. Westcott, M.D.

1315 Tibbals

Holdrege, Nebraska 68949

Books



The health practitioner in family relationships: sexual and marital issues; edited by Eugenia L. Gullick, Ph.D. and Steven F. Peed, Ph.D.; 143 pages; hard cover, \$15.00; published 1978 by Technomic Publishing Company, Westport, CT.

The book is meant for family physicians and family-counseling social workers (and ministers, the accompanying description says). It is divided into 12 chapters, including sex and aging, the divorced patient, sexual dysfunctions, and the changing sociology of the family.

There are 8 contributors (2 are the editors); 5 are MDs and 3 are PhDs. There is an index, and unnumbered references. The editors are with the Institute of Family Living at the Medical College of Virginia. The authors are, the release says, MDs and PhDs in medicine and psychiatry.

It is a pleasant little book which makes for carrying with you and easy reading when meetings break up early or you are eating alone. I do not know how much good can be done for premature ejaculation, secondary impotence, or vaginismus, but patients ask for relief in these quarters, and we must know how to treat them.

It is a good little book; it is well written.

—F.C.

General urology; edited by Donald R. Smith, M.D.; 542 pages; limp cover \$14.50; published 1978 by Lange Medical Publications, Los Altos, California 94022.

This book is in its 9th edition, having first appeared in 1957, so that a new edition comes out every two or three years. The editor is chief of the Section of Urology at Rutgers Medical School. There are 35 chapters, written by 22 authors. The print is good and reading is easy; there is a fine index, unnumbered references, figures; and beautiful photographs, including x-rays.

Rewritten and revised sections include anatomy, obstruction, reflux, neuropathic bladder disorders, disorders of the female urethra, schistosomiasis, chemotherapy of malignancy, computed tomography, and infection.

The test is available in Spanish, Japanese, and Polish editions; and it will be translated into German, Italian, and Portuguese. Psychomatic aspects of urology and infertility are treated in the final chapters.

The book is recommended.

—F.C.

Books received.

Occupational disease: a syllabus of signs and symptoms; by E. R. Plunkett, M.D.; 352 pages; \$22.95 plus handling, hard cover; published 1977 by the Barrett Book Company, 388 Summer Street, Stamford, Connecticut 06901.

352

Tenuate®
(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976
MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633
Direct Medical Inquiries to
MERRELL-NATIONAL LABORATORIES
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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

Merrell

B-3921 (Y587A)

**Whether overweight is a
complicating factor...
or just uncomplicated overweight.**

Tenuate[®] Dospan[®] ^{IV} **(diethylpropion hydrochloride NF)** **75 mg. controlled-release tablets**

A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with hypertension, symptomatic cardiovascular disease, or diabetes. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. (Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.)

In uncomplicated obesity.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

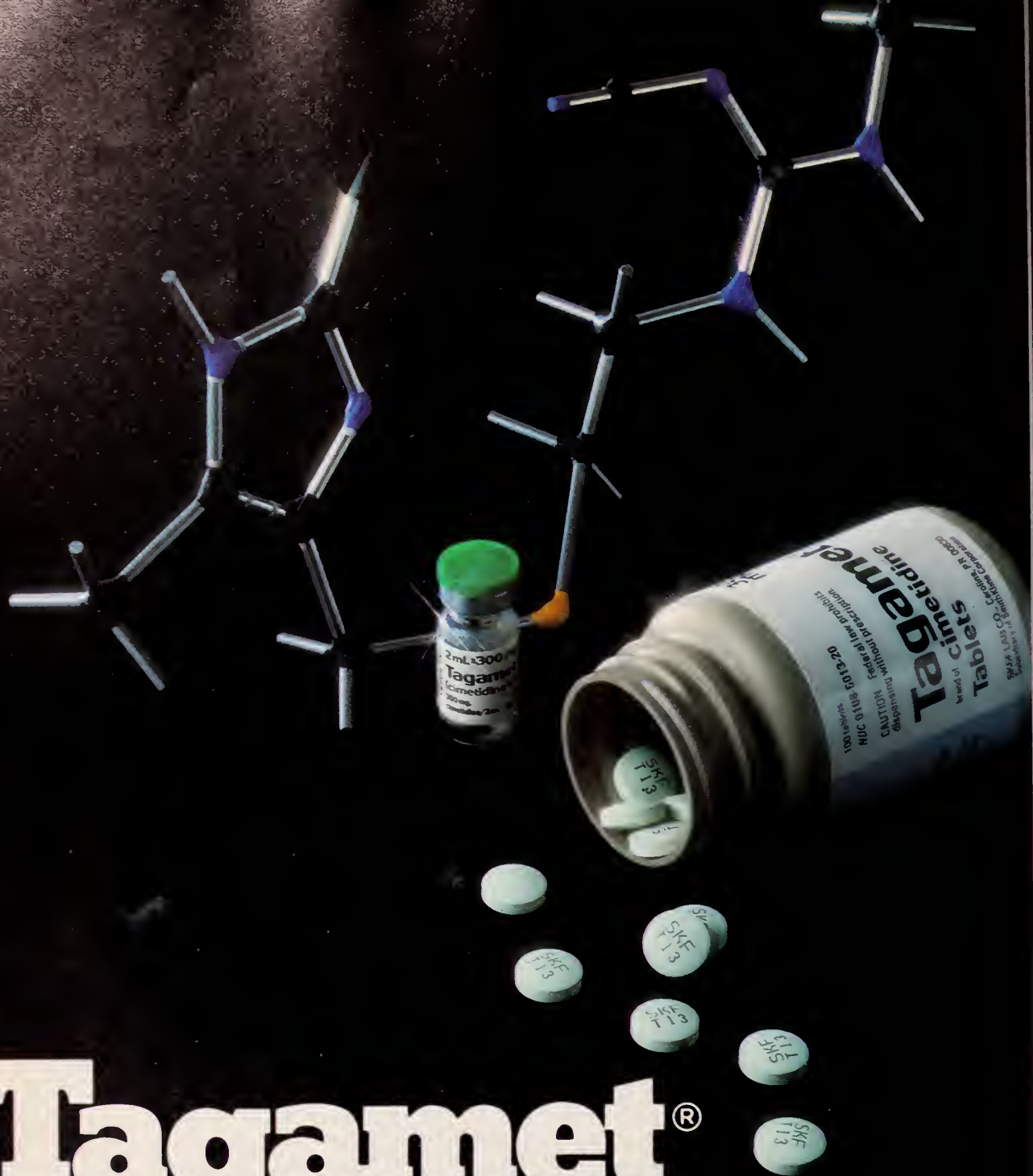
The anorexic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.¹ And the unique chemistry of Tenuate provides "...anorexic potency with minimal overt central nervous system or cardiovascular stimulation."² Compared with the amphetamines, diethylpropion has minimal potential for abuse.

**Tenuate—it makes sense.
And it's responsible medicine.**

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For prescribing information see opposite page.



Tagamet[®]

brand of

cimetidine

How Supplied: Pale green, 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only).

Injection, 300 mg./2 ml., in single-dose vials in packages of 10.

SK&F LAB CO.
a SmithKline company

The Letter Box

Dear Dr. Cole:

Dr. Beavers called me to tell me that the time and place of the 25th Annual Scientific Session of the Nebraska Obstetric & Gynecologic Society (NOGS) has been changed. Could you please include a notice in the next issue of the journal to include:

PLEASE NOTE CHANGE OF DATE
AND LOCATION

Nebraska Obstetric & Gynecologic Society
25th Annual Scientific Session
Thursday, Friday, and Saturday

November 16, 17, & 18, 1978
MGM Grand Hotel - Las Vegas, Nevada
For further information:

Dennis Beavers, M.D.
Secretary-Treasurer
8552 Cass Street
Omaha, Nebraska 68114

Thank you.

Sincerely,
Marjorie E. Adey
Secretary

Coming Meetings

NEBRASKA MEDICAL ASSOCIATION —
Fall Session, September 27-29, 1979, Lincoln Hilton Hotel, Lincoln, Nebraska.

CRIPPLED CHILDREN'S CLINICS —
October 7 — Alliance, Central School Building
November 4 — Hartington, Trinity Lutheran Church

RADIOLOGISTS MEET — The Society of Gastrointestinal Radiologists is conducting a postgraduate course on "Diagnostic Imaging of the Gastrointestinal Tract" at Tan-Tar-A, Lake of the Ozarks, Missouri from October the 12th to October the 15th, 1978. The faculty will be drawn from the membership of the Society of Gastrointestinal Radiologists and includes leading academic radiologists from the entire country. The registration fee is \$225. The course is co-sponsored by the American College of Radiology with approval for category I credit of 13 hours. Further information and application materials can be obtained from the president of the society, Walter M. Whitehouse, M.D., Department of Radiology, University of Michigan Hospital, Ann Arbor, Michigan 48109

OMAHA MID-WEST CLINICAL SOCIETY:
46th Annual Postgraduate Assembly; Omaha Hilton Hotel; October 30, 31 and November 1, 1978. Write to: Lorraine E. Seibel, Executive Secretary, Omaha Mid-West Clinical Society, 540 Medical Arts Building, Omaha, Nebraska 68102.

AMERICAN MEDICAL ASSOCIATION —
Interim Session, House of Delegates, December 2-6, 1978, Palmer House, Chicago, Illinois.

AMERICAN MEDICAL ASSOCIATION —
Winter Scientific Program, December 7-10, 1978, Las Vegas, Nevada.

RADIOLOGY OF THE ACUTELY ILL AND INJURED PATIENT — UPDATE 1979; January 26-27, 1979; Stouffer's Hotel, Greenway Plaza, Houston, Texas. Presented by The University of Texas Medical School at Houston, Department of Radiology. Co-sponsored by The University of Texas Health Science Center at Houston, School of Allied Health Sciences and Division of Continuing Education. Fee: \$150.00; write to: Division of Continuing

Education, The University of Texas Health Science Center at Houston, P.O. Box 20367, Houston, Texas 77025. This course meets the criteria for 14 credit hours in Category I of the Physician's Recognition Award of the American Medical Association, provided it is used and completed as designed. Application has been made to the American College of Emergency Physicians for 14 ACEP Category I credits, and to the American

Academy of Family Physicians for 14 Prescribed credit hours.

NEBRASKA MEDICAL ASSOCIATION — Annual Session, April 29 - May 2, 1979, Holiday Inn, Kearney, Nebraska.

AMERICAN MEDICAL ASSOCIATION — Annual Convention, July 22-26, 1979, Chicago, Illinois.

Physicians' Classified

Advertisements in this column are run at a rate of twenty cents per word with a minimum of \$10.00 per insertion. Copy must be received by the fifth of the month preceding date of publication and should not exceed 50 words. Each advertisement will be taken out following its first appearance unless otherwise instructed. Where numbers follow advertisements, replies should be addressed in care of The Nebraska Medical Journal, 1902 First National Bank Building, Lincoln, Nebraska 68508.

PSYCHIATRIC RESIDENCY: Vacancies for (PG2 through PG4 only) positions starting January 1, 1979, for those who have regular Iowa license or can obtain one by reciprocity or via FLEX. Prepare for a career in private practice, community clinics or hospital based psychiatry. Emphasis on close supervision of intensive individual and group psychotherapy, OPD, Children's Unit, Adolescent Unit. Neurology affiliation with University of Iowa. The stipends are: 1st year, \$23,478; 2nd year, \$24,648; 3rd year, \$25,896. Intensity and diversity of training program appreciated best by personal visit. T. B. McManus, M.D., Superintendent, Mental Health Institute, Cherokee, Iowa 51012. Equal opportunity employer. Call collect 712-225-2594.

OPPORTUNITY IN FAMILY PRACTICE. Two Board Certified Family Physicians need third physician. New office connected to new hospital (250 beds) with all ancillary and specialized services available. Any interested physicians please sent curriculum vitae to Link, Chapman & Associates, Inc., 1515 West Truman Road, Independence, Missouri 64050, or call collect 816-836-8200; 9:00 A.M. to 4:30 P.M.

SIOUX FALLS FAMILY PRACTICE RESIDENCY is seeking a full-time assistant director. Position open immediately. Program size presently 28 residents enlarging to 36. A strong affiliation exists with the University of South Dakota School of Medicine and appointments to the faculty are available. Board certification required and experience in Family Practice desirable. Salary negotiable. Send resume to L. J. Sweeney, M.D. or Howard Hoody, M.D., 1800 South Summit Avenue, Sioux Falls, SD 57105. (605) 339-1783. Equal opportunity/affirmative action employer.

MEDICAL DIRECTOR — General practitioner to perform general examination, care, and treatment of patients at state psychiatric hospital. Forty-hour week with rotating on-call duty. No surgery. Starting salary of \$41,000 to \$45,000, depending on experience. Excellent benefits. Contact: H. D. Herrick, M.D., Superintendent, Norfolk Regional Center, Box 1209, Norfolk, Nebraska 68701. Call Collect: 402-371-4343.

EXCELLENT OPPORTUNITY — for a physician in Cedar Rapids, Iowa. Excellent medical facilities in city. Assume practice of deceased sole practitioner of internal medicine. Office leased; laboratory and x-ray facilities close at hand. Write: Trust Dept., P.O. Box 1807, Cedar Rapids, Iowa 52406.

10-78

Picture Gallery

NMA 1978 Annual Session



Doctor Arnold W. Lempka and guest speaker, Mr. Irving R. Levine.



Doctors James H. Rickman and Houtz G. Steenburg.



Annual Distinguished Luncheon.



Annual Distinguished Luncheon.



Annual Distinguished Luncheon.



Doctor James H. Rickman presiding at Annual Distinguished Luncheon.



Doctor Arnold W. Lempka congratulating the new incoming President, Doctor Houtz G. Steenburg.

Picture Gallery

NMA 1978 Annual Session



Doctor Arnold W. Lempka presenting President's medallion to Doctor Houtz G. Steenburg.



Doctor Arnold W. Lempka presenting President's badge to Doctor Houtz G. Steenburg.



Doctor Arnold W. Lempka presenting President's gavel to Doctor Houtz G. Steenburg.



Doctor Arnold W. Lempka presenting "special" plaque to Doctor Houtz G. Steenburg.



Doctor Houtz G. Steenburg presenting Past President's badge to Doctor Arnold W. Lempka.



Doctor Houtz G. Steenburg presenting Past President's plaque to Doctor Arnold W. Lempka.



Guest speaker, Mr. Irving R. Levine, addressing Annual Distinguished Luncheon audience.



Annual Distinguished Luncheon.



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WashingtonNotes

Distribution of doctors & \$430 million.

One of the thornier problems confronting health care planners, policymakers and providers, the geographic distribution of health manpower, particularly physicians, was the subject of a recently completed study by the General Accounting Office.

In a report to Congress the GAO said that \$430 million in federal funds had been spent during fiscal years 1972-1977 in an effort to increase the supply of physicians in shortage areas.

According to the GAO, some 384,900 nonfederal physicians — 369,800 MDs and 15,100 doctors of osteopathy — are unevenly distributed throughout the United States. Of the MDs, approximately 292,200 (79 percent) are providing patient care. But although this works out to 137 physicians for each 100,000 persons, a disproportionately large number are located in urban areas, where the physician-to-population ratio is significantly higher than in rural areas. Furthermore, the GAO reported, distribution is also inequitable within urban centers.

As for the 20,000 new physicians on whom data were available, they followed the path of their predecessors: 90 percent of the 1967-1971 U.S. and foreign medical graduates licensed located in cities.

Reporting on the National Health Service Corps, the GAO told Congress:

"The Corps has undoubtedly increased the availability of physicians' services in communities designated by HEW as having a critical shortage of health manpower. However:

"The Corps has not adequately considered the demand for medical services when assessing the need for physicians in shortage areas. This, coupled with its decision to place a minimum of two physicians at most sites to the extent possible, has resulted in many physicians being underused in terms of patients served at sites in operation one year or longer.

"The Corps has experienced difficulty in recruiting physicians willing to voluntarily practice in the more remote, less populated areas. Consequently, many of these sites have remained unstaffed for periods ranging up to 4 years.

"Corps officials look to the HEW scholarship program with its shortage area service obligation to provide a sufficient supply of physicians in the future. But because of deferments for graduate medical education, HEW officials do not expect a substantial number of physicians to be available until fiscal year 1979.

"It should be recognized, moreover, that the number of physicians authorized by the Corps for its unstaffed sites may exceed the number needed as evidenced by the low use of Corps physicians at many sites in operation one year or longer.

"From inception through July 1976, only 42 physicians — out of a total of about 800 who served in the Corps — remained in the shortage areas or were planning to do so, as private practitioners, which is a major program objective."

As for loan repayment programs, the GAO found them relatively ineffective.

"As of October 31, 1977," the report said, "The Federal loan repayment program attracted only 762 physicians (about 1.7 percent of those eligible) to shortage areas in return for loan repayment. Moreover, the majority of those who participated through February 1976 probably would have established practices in those shortage areas anyway. Thus, it seems the program provided financial benefits predominately to physicians who already had decided on shortage area practice."

The GAO found it hard to assess the effectiveness of area health education centers.

Both the preceptorship and family medicine training programs were too new at the

time of GAOs review to determine their impact on increasing the supply of physicians in shortage areas.

In an effort to assess state and private efforts to improve access to primary care medical services in rural areas through programs relying heavily on nonphysician providers (including nurses and physician extenders) the GAO visited four such programs:

The North Carolina Rural Health Centers; Kentucky Frontier Nursing Service; Checkerboard Area Health System; and East Kentucky Health Services Center. All use physician extenders as principal providers of health care in rural clinics. The physician extenders provide services under the supervision of physicians, but physicians are not always present when the services are performed.

The inability to receive reimbursement from Medicare (part B) and some other third-party payers for physician extender services at independent sites such as those discussed above had apparently restricted their potential widespread use.

"In GAO's view, now that reimbursement for physician extender services rendered in rural clinics in underserved areas has been authorized, projects which rely extensively on physician extenders at satellite clinics or in mobile units with backup from physicians in larger neighboring communities could constitute an approach for providing health care to communities in the nation otherwise unable to attract or retain physicians."

The General Accounting Office recommended that the Secretary of Health, Education, and Welfare should:

"Develop guidelines for assessing under what circumstances it would be appropriate to assign health care providers to entities requesting Corps assistance and the number and type of provider(s) that would be most appropriate.

"Require communities and other entities requesting Corps health care providers to conduct studies which identify, to the extent possible, the number and types of residents

located therein who are likely to seek care from a Corps-sponsored practice.

"Develop multiyear projections to assess the total number of physicians with scholarship commitments that will be needed to serve in shortage areas.

"Make an analysis of the extent to which family practitioners and other specialists are locating in HEW-designated shortage areas and, based upon this analysis, submit to the Congress recommendations for financially supporting those programs which constitute the greatest resource for providing health care to medically underserved areas.

"Work with the states to identify those areas having health manpower distribution problems and develop a strategy for marshaling resources — Federal, State, and private — to establish an integrated program designed to provide health services in the manner most appropriate to each area.

"Examine those programs which rely on physician extenders to help deliver health services to those areas otherwise unable to attract physicians and consider seeking legislation which would provide federal funds to help develop those programs found to be most useful."

Addressing its recommendations to Congress, the GAO said it believes "it is doubtful that a separate loan repayment program is still needed to attract physicians to shortage areas in view of the (1) expanded Corps scholarship program and number of physicians expected to be available for shortage area service; and (2) discretion available to the Secretary of HEW under the Health Professions Educational Assistance Act of 1976 to repay the newly authorized federally insured health professions student loans.

"Therefore, the Congress should reconsider whether the loan repayment program for physicians needs to be continued since

"it has not induced substantial numbers of physicians to enter shortage area practice and

"many physician participants apparently received windfall repayment of their education loans by the Federal Government

since they would have established their practices in those shortage areas anyway."

The report continued:

"The Congress should also reconsider the necessity for HEW to complete its study on physician extender reimbursement as required by the Social Security Amendments of 1972 in view of the

"recent legislation enacted that provides

for (1) Medicare (part B) and Medicaid reimbursement for physician extender (physician assistants and nurse practitioners) services rendered in certain rural health clinics in medically underserved areas; and (2) demonstration projects to be conducted with respect to reimbursement for services provided by physician-directed clinics which employ physician assistants and nurse practitioners."

Oral Zinc Therapy of Acne — L. Orris et al
(Mount Sinai School of Medicine, New
York, NY 10029) Arch Dermatol 114:1018-
1020 (July) 1978.

In a double-blind controlled comparison that lasted eight weeks, tablets of zinc sulfate monohydrate, 411 mg total daily dosage, and a lactose placebo were administered orally to 22 male subjects with moderate acne. Levels of zinc were determined in serum and urine. There were no statistically significant differences in the lesion counts (papules, pustules, open comedones, and closed comedones) in the zinc-treated and lactose-treated cases, despite evidence in serum and urine of absorption of zinc. Oral zinc therapy has no early clinical effect on male patients with moderate acne.

Tinel's Sign — J. Moldaver (30 E 60th St,
New York, NY 10022) J Bone Joint Surg
60-A:412-414 (April) 1978.

In 1915, Tinel, after studying a large number of peripheral nerve injuries, described a tingling sensation or so-called formication sign produced by slight percussion of a nerve trunk some time after an injury. Tinel indicated that pressure applied to a regenerating nerve trunk will cause tingling. An identical tingling phenomenon can be produced by stimulation of a sensory or mixed nerve through the skin using a square-wave current, a negative pole (cathode; stimulating electrode which is one centimeter in diameter and applied over the nerve, and a larger position (anode) or diffuse electrode applied elsewhere. A true Tinel sign, therefore, is a tingling sensation elicited by stimulation of nerve branches in which touch fibers are growing. Since in a mixed nerve touch fibers account for only about 10% of all of the fibers, only a few touch fibers are needed to produce Tinel's sign, and the sign provides information about the regeneration of the touch fibers but not of the other fibers. A true Tinel sign is never painful.

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Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

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Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).



Roche Laboratories
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Nutley, New Jersey 07110

Please see back cover.

Her next attack of cystitis may require

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3-system counterattack



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Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of

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Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

BALCONY

The Nebraska Medical Journal

November, 1978

NEW YORK
NY 10029

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- ☐ Minimal effect on mental acuity
- ☐ Predictable patient response
- ☐ Is used concomitantly with primary medications, such as anticholinergics and cardiovascular drugs

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chlordiazepoxide HCl/Roche



5mg, 10mg, 25mg capsules

synonymous with relief of anxiety

Please see next page for summary of product information.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction, changes in EEG patterns (low-voltage fast activity) may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

Prophylactic Doxycycline for Travelers' Diarrhea — D. A. Sack et al (Baltimore City Hosp, Baltimore, MD 21224) *N Engl J Med* 298:758-763 (Apr 6) 1978.

In a randomized double-blind study to determine the efficacy of doxycycline (100 mg daily) in preventing travelers' diarrhea, 39 Peace Corps volunteers during their first five weeks in Kenya took either doxycycline or placebo for three weeks and were observed for an additional two weeks. Nine of 21 taking placebo and one of 18 taking doxycycline had travelers' diarrhea during the treatment period ($P = .012$). The protection seemed to persist for at least one week after the drug was stopped. Enterotoxigenic *Escherichia coli* was the only pathogen isolated from the placebo group, but was not detected in persons taking doxycycline. None of these organisms were resistant to doxycycline or tetracycline, whereas resistance to tetracyclines and other antibiotics was common among the nonenterotoxigenic *E. coli*. Doxycycline effectively prevented most episodes of travelers' diarrhea.

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Manuscripts should be typewritten, double-spaced, on one side only, of firm letter size [8½ x 11 in. (22 x 28 cm)] white paper; leave wide margins; do not use script or all capital letters. Show the author's name, degree, and credits on the title page. Number all pages in the right upper corner, with the author's surname.

Illustrations should be numbered, identified by placing, on the back, the author's name, its number, and the word top. Their locations should be shown in the text.

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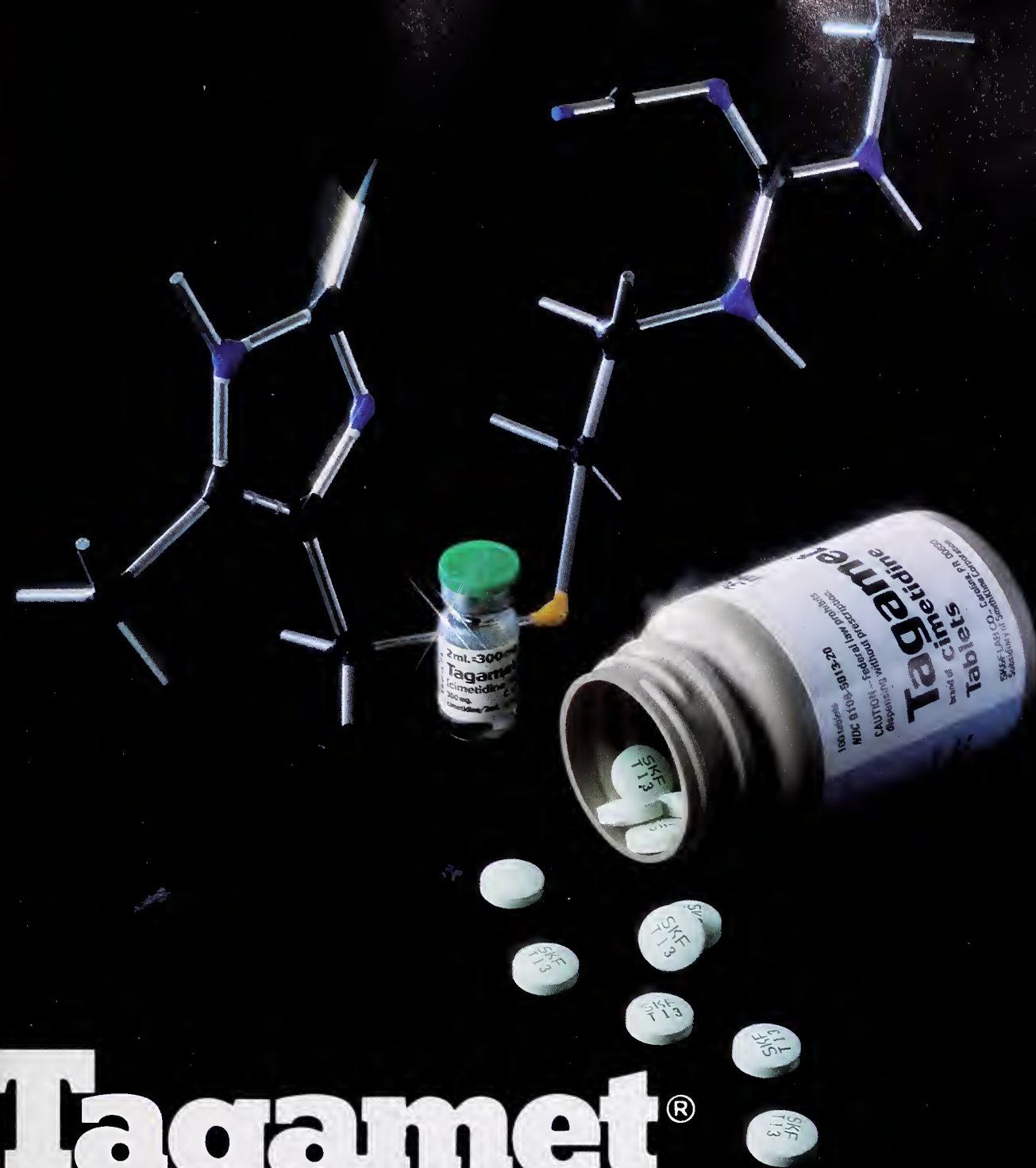
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**When painful spasm
is the presenting
symptom...**



in functional G.I. disorders*

Bentyl[®]

(dicyclomine hydrochloride USP)

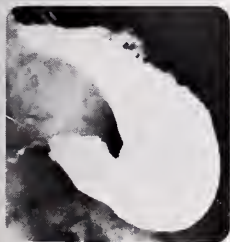
10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity
with minimal anticholinergic side effects[†]

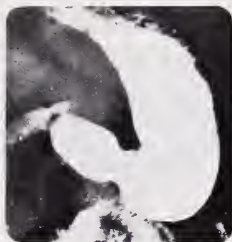
Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating certain functional G.I. disorders.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection
AVAILABLE ONLY ON PRESCRIPTION.

Brief Summary

INDICATIONS

For use as adjunctive therapy in the treatment of peptic ulcer. IT SHOULD BE NOTED AT THIS POINT IN TIME THAT THERE IS A LACK OF CONCURRENCE AS TO THE VALUE OF ANTICHOLINERGICS/ANTISPASMODICS IN THE TREATMENT OF GASTRIC ULCER. IT HAS NOT BEEN SHOWN CONCLUSIVELY WHETHER ANTICHOLINERGIC/ANTISPASMODIC DRUGS AID IN THE HEALING OF A PEPTIC ULCER, DECREASE THE RATE OF RECURRENCES, OR PREVENT COMPLICATION.

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FOA has classified the following indications as "probably" effective.

May also be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders); and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon).

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloro-duodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with autonomic neuropathy, hepatic or renal disease, ulcerative colitis—Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon; hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension; hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis). Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. **ADVERSE REACTIONS:** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste, headache, nervousness, drowsiness; weakness; dizziness, insomnia, nausea, vomiting, impotence, suppression of lactation, constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup. **Adults:** 1 or 2 capsules or teaspoonfuls syrup three or four times daily. **Children:** 1 capsule or teaspoonful syrup three or four times daily. **Infants:** ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) **Bentyl 20 mg. Adults:** 1 tablet three or four times daily. **Bentyl Injection:** **Adults:** 2 ml. (20 mg.) every four to six hours intramuscularly only. **NOT FOR INTRAVENOUS USE.** **MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of October, 1976

Predictors of Mortality in Presenile and Senile Dementia — A. W. Kaszniak et al
(Rush Medical College, Chicago, IL 60612)
Ann Neurol 3:246-252 (Mar) 1978.

Forty-seven hospitalized patients with a diagnosis of presenile or senile dementia and without focal neurological disease or major systemic illness were given complete neurological, neuroradiological, and neuropsychological examinations. At one year after hospitalization, 12 patients were lost to follow-up; of the remaining 35 patients, 19 were alive and 16 had died. These two groups did not differ in age, education, length of dementia history, sex, race, or degree of cerebral atrophy (by computerized tomography). Significant differences were found in degree of electroencephalographic abnormality and in eight of 14 cognitive measures, the largest single difference being on a test of expressive language. Discriminant function analysis made with the cognitive measures as dependent variables yielded a correct prediction (classification analysis) of mortality in all but one case (97%) accuracy. These results suggest that (1) degree of functional brain impairment rather than degree of cerebral atrophy may be the more important influence on mortality in dementia patients without focal lesions, (2) short-term survival may be accurately predicted in such patients by tests of cognitive functioning, and (3) expressive language deficit in such patients may indicate a particularly poor prognosis for survival.

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PERCOCET-5 ^{Tablets}

Brief Summary of Prescribing Information

DESCRIPTION Each tablet of PERCOCET®-5 contains 5 mg oxycodone hydrochloride (WARNING: May be habit forming), 325 mg acetaminophen (APAP).

INDICATIONS For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS Hypersensitivity to oxycodone or acetaminophen.

WARNINGS Drug Dependence Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of PERCOCET®-5, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, PERCOCET®-5 is subject to the Federal Controlled Substances Act.

Usage in ambulatory patients Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using PERCOCET®-5 should be cautioned accordingly.

Interaction with other central nervous system depressants Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with PERCOCET®-5 may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Usage in pregnancy Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, PERCOCET®-5 should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Usage in children PERCOCET®-5 should not be administered to children.

PRECAUTIONS Head injury and increased intracranial pressure The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions The administration of PERCOCET®-5 or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special risk patients PERCOCET®-5 should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

ADVERSE REACTIONS The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, skin rash and pruritus.

DOSEAGE AND ADMINISTRATION Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. PERCOCET®-5 is given orally. The usual adult dose is one tablet every 6 hours as needed for pain.

DRUG INTERACTIONS The CNS depressant effects of PERCOCET®-5 may be additive with that of other CNS depressants. See WARNINGS. 6085 BS

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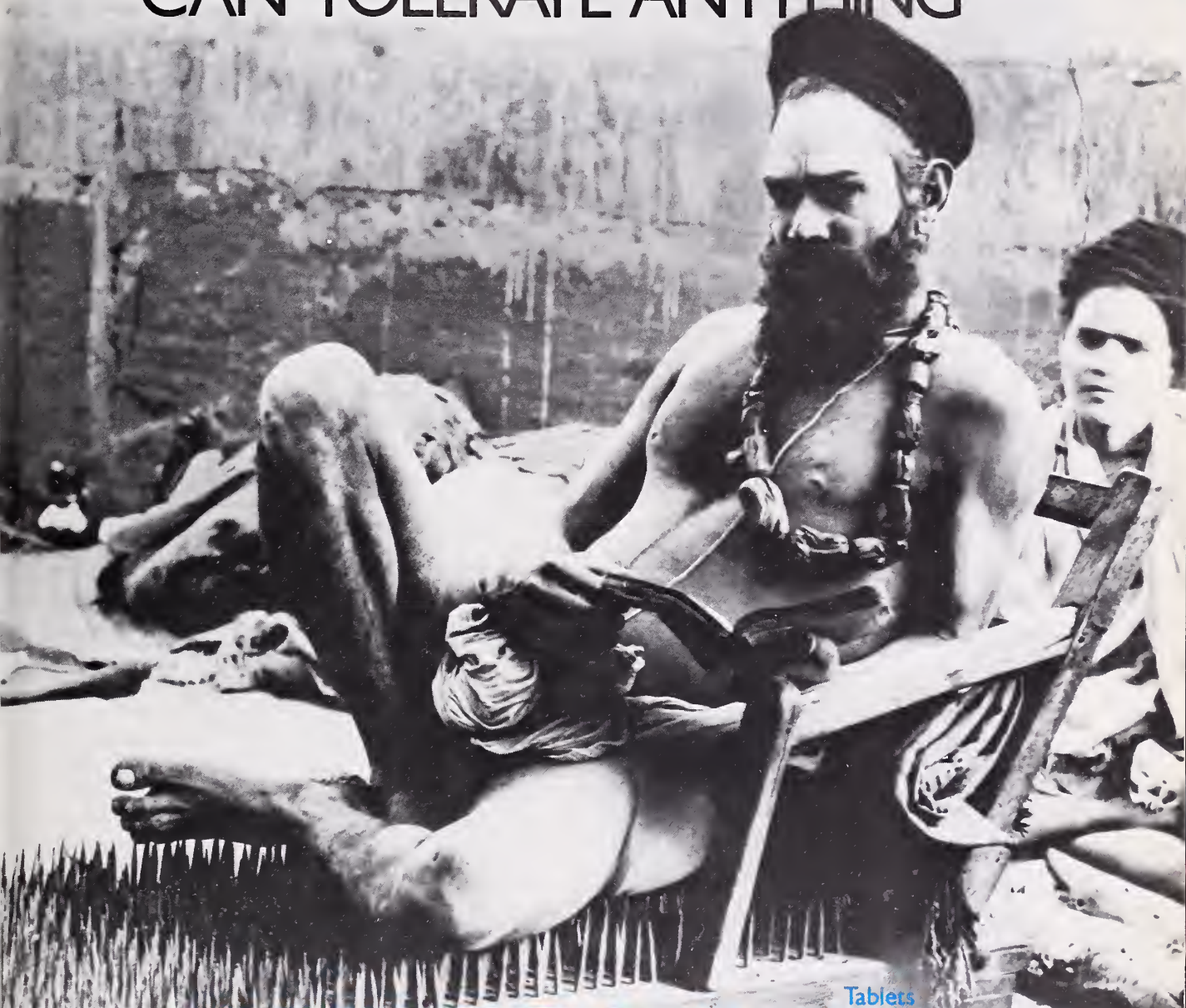
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 - ☐ convenient, economical q6h dosage

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Psychiatric Antecedents of Myocardial Infarction — G. Bianchi et al (142 Ferny Ave, Surfers Paradise, Queensland, Australia) Med J Aust 1:297-301 (Mar 25) 1978.

Forty consecutive survivors after myocardial infarction (MI) were compared by means of a semistructured interview with a matched sample of 40 controls for various psychosocial factors. The MI group had a much higher prior occurrence of anxiety and depression symptoms, which included complaints of being tired, irritable, restless, upset and anxious, plus insomnia and anhedonia. Preceding stressful life events were about 2½ times more common in the MI group. However, long-term personality traits which were not recent additions due to psychiatric change before MI did not strongly discriminate between the two groups, and recognized variables such as cigarette smoking had a lesser association with MI. Similar results were obtained when information about each patient and each control was supplied by a close informant.



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The First Decade of Aortocoronary Bypass Grafting, 1967-1977 — H. D. McIntosh (Watson Clinic, PO Box 1429, Lakeland, FL, 33802) and J. A. Garcia, *Circulation* 57:405-430 (Mar.) 1978.

Despite a decade of experience with aortocoronary bypass grafting totaling 300,000 or more operations, indications for its use remain controversial. The controversy persists because of a lack of adequate controls with which to compare the clinical course of operated patients; only 1,248 have been reported who have been studied in a carefully controlled and random manner. Benefit has been claimed frequently by comparing the course of patients treated surgically with medically treated patients followed the decade before. Such comparisons are not valid in view of the well documented changes in the natural history of coronary artery disease that have occurred during the last decade. Despite a low operative mortality and rate of graft closure, available data do not indicate that initial symptomatic improvement necessarily persists, or that myocardial infarctions, arrhythmias, or congestive heart failure will be prevented, or that life will be prolonged in the vast majority of patients.

Hazards of Succinylcholine Administration During Electrotherapy — P. M. Packman et al (Barnes and Renard Hospitals, St. Louis, MO 63110) *Arch Gen Psychiatry* 35: 1137-1141 (Sept) 1978.

Prolonged apnea following electrotherapy was observed in a patient who was also being treated for glaucoma with a topical organophosphate anticholinesterase, ecothiophate iodide (phospholine iodide). The increased duration of action of succinylcholine resulted from low levels of serum cholinesterase that had been caused by the organophosphate. Attention is called to other drugs that directly or indirectly (by lowering serum cholinesterase) interact with succinylcholine chloride resulting in prolonged apnea. Other potential hazards of succinylcholine administration are hyperkalemia and cardiac arrhythmias.

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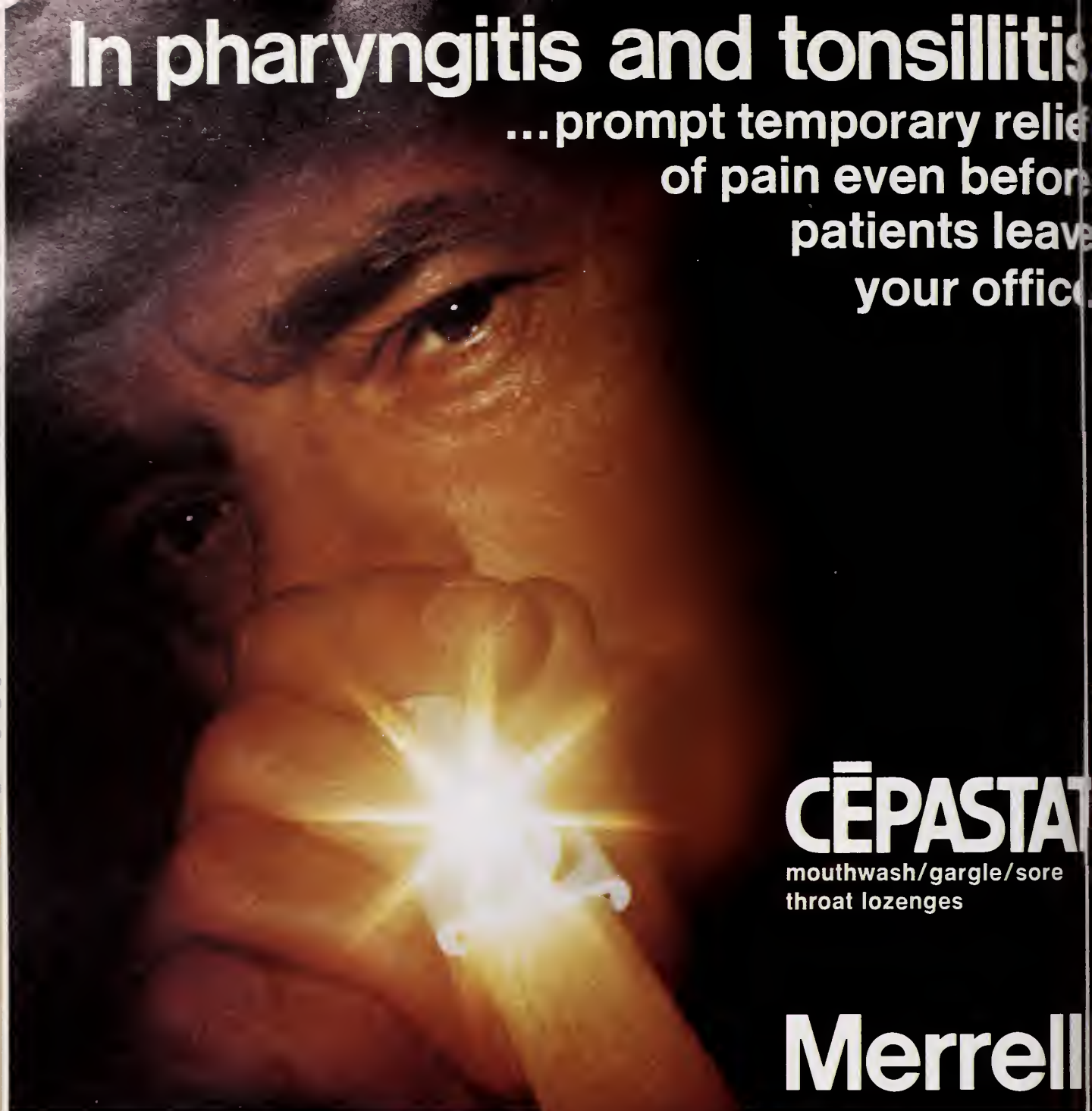
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Cystosarcoma Phyllodes — A. Al-Jurf et al (Cleveland Clinic Hosp, Cleveland, OH 44106) Surg Gynecol Obstet 146:358-364 (Mar) 1978.

Recurrence and metastases of a cystosarcoma phyllodes are poorly correlated with the histologic type and treatment used. There is some evidence that the prognosis is more favorable for small tumors and minimal cellular atypism. Local excision seems to be associated with a higher incidence of tumor recurrence. Metastases can develop later from what appears primarily a benign, as well as a malignant, tumor. Mastectomy as primary treatment was not always effective in preventing local recurrence; if the tumor recurred after mastectomy, it gave rise to fatal metastases. The recurrence of the tumor after local excision is secondary to microscopic foci retained after enucleation. A local excision should include a wide margin of mammary tissue around the tumor. Wide local excision for small, slow growing and clinically benign tumors can be used as a first operation, with wider re-excision and

later mastectomy if the tumor recurs. Large and rapidly growing tumors that suggest malignant disease should be removed primarily by mastectomy.

Prevention by Bedtime Cimetidine of Duodenal Ulcer Relapse — W. S. Blackwood et al (T. C. Northfield, St. George's Hosp. Medical School, London, England), Lancet 1:626-627 (Mar. 25) 1978.

Forth-five patients with healed duodenal ulcers completed a six-month double-blind trial which compared the effects of cimetidine and placebo on the prevention of duodenal ulcer relapse. A single bedtime dose of cimetidine 800 mg) was given and ulcer relapse was assessed endoscopically at regular intervals. At the end of the trial, 16 of the 21 (76%) cimetidine-treated patients remained ulcer-free compared with only three of the 24 (12.5%) placebo-treated patients.

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Treatment of Idiopathic Polyneuritis by a Polyunsaturated Fatty Acid Diet — B. D. Bower (Radcliffe Infirmary, Oxford, England) and E. A. Newsholme, *Lancet* 1:583-585 (Mar 18) 1978.

Two children who were severely disabled for six and 12 months respectively by idiopathic polyneuritis began to recover within a week of starting on a polyunsaturated fatty acid diet. Recovery is virtually complete.

Spontaneous Rupture of Liver and Spleen During Streptokinase Treatment of Deep Venous Thrombosis — L. Norgren et al (Dept. of Surgery, Univ. of Lund, Lund, Sweden) *Lakartidningen* 75:777-778 (Mar. 1) 1978.

Serious complications during treatment of deep venous thrombosis with streptokinase are described. In four patients spontaneous liver rupture occurred in three and a splenic rupture in one. Two patients were saved by surgery and two died, one postoperative, one before operation. The cause of bleeding is not clear, but seems to be a specific effect of streptokinase on the liver. Liver disease could not be found in any case.

Reduction in Incidence of Rheumatoid Arthritis Associated With Oral Contraceptives — Royal College of General Practitioners (G. R. Kay, RCGP Research Unit, Manchester, England) *Lancet* 1:569-571 (Mar 18) 1978.

Analyses of the frequency of reporting of rheumatoid arthritis was undertaken as part of the continuing major prospective survey of oral contraceptives. The rate of reporting in oral contraceptive users (takers) is half of the rate in non-users (controls). The rates for ex-takers and controls are not materially different. The expected rise in the rate of reporting in women over 35 years of age is apparent in controls but suppressed in takers. In the absence of any accountable bias, it is concluded that oral contraceptives protect against the development of rheumatoid arthritis. Although the effect is small, the observation may be valuable in understanding the etiology of the disease and the mechanism of action of oral contraceptives.

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Calcium Needed To Maintain Bone Health

Recent evidence suggests that long-term calcium inadequacy may contribute to the development of osteoporosis in later life.

While there are many causes for bone loss during aging, the primary factor is long-term inadequate consumption of calcium in the diet, according to Anthony A. Albanese, Ph.D., of the Burke Rehabilitation Center in White Plains, N.Y.

For the past several years, Dr. Albanese and his associates have been involved with research on the detection of skeletal bone loss in elderly individuals. By studying X-ray films taken of the fingers of his patients, Dr. Albanese saw how different amounts of calcium in the diet affected the bone density. Bone loss, he found, can be retarded and bone density improved by increasing the calcium intake.

He has concluded that in order to maintain good

bone density, adult individuals should have a daily intake of at least one gram (1000 mg) of calcium for the remainder of their lives. Currently, the Recommended Dietary Allowance (RDA) for calcium for adults is 800 mg. per day.

Dr. Albanese has pointed out that "among the common foods, milk and its products are the richest sources of calcium." In order to achieve Dr. Albanese's recommended level of 1000 mg of calcium daily, one would consume three servings from the milk group. A serving would be one eight-ounce glass of milk, one and a half ounces of hard cheese or a cup of yogurt. Other foods provide some calcium, but in lesser amounts.

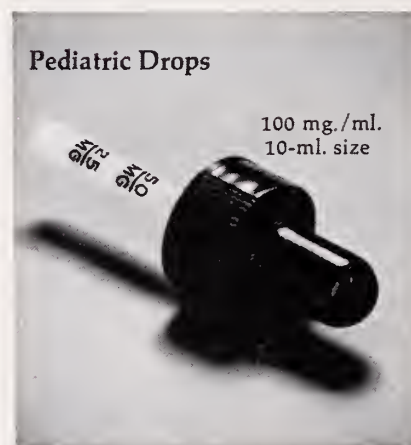
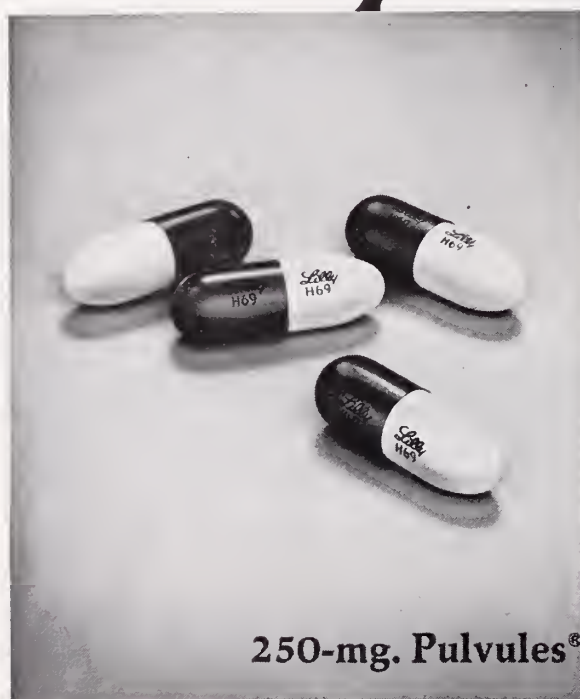
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THE NEBRASKA MEDICAL JOURNAL

FOLLOW IT, FOLLOW THE GLEAM

We are besought on every turn; we practice an art, and a humanity of an unsurpassed order, and somehow a business. The old-time doctor did little to save the patient; his respect varied with the ages from very little to an unequalled height to what it is now, while he sometimes disdained to talk of fees. The art of medicine and the image of its practitioner vary with the century, its economic side meanwhile changes radically before our eyes. The laborer is worthy of his hire, no less the physician, who, whenever he thinks it necessary, adds philanthropy to art. We deserve little of the too-much criticism we receive. For we remember that we were all of us asked, when we entered, why we wanted to be doctors, and how much we wanted it, that we knew it was not a business. That there was something about it that was different from anything else, that there was something magic that attracted us.

If our practice becomes a humdrum thing, if it becomes monotonous, if we forget how very different our chosen path is, we have forgotten why we elected to do what we now do every day of our lives, we have forgotten the wonderful feeling we knew when we began to be doctors, we have unfortunately forgotten that we meant to pursue something wonderful, that we were intended to follow the gleam.

There are many who have won their fifty year pins who know this and who remember. But are there not critics who do not? Ours is the most different of all professions. We have all of us taken the most curious of oaths to say so. We may work long hours and hard days and sleepless nights and wonder why, and forget the graduation ceremony, but we should not. For the dream was right as we dreamed it, and the gleam we follow may be as the will-o-the-wisp, but if we forget that we set out to follow it we have lost everything that was wonderful. No, we have not forgotten, we will never forget that, however arduous the daily task, we still, all of us, follow the gleam.

—F.C.

NEBRASKA, CREIGHTON, AND BAKKE

We all waited for the Bakke decision.

The June, 1971 issue of the Journal contained articles from Creighton and the University of Nebraska, explaining their methods of selecting students for admission to their medical schools.

The Journal does not solicit manuscripts, but these articles were asked for, and so were the two that appear in this issue. Both of our medical schools were asked to tell us again something about their admissions policies, and particularly to explain the effect of the U.S. Supreme Court Bakke decision on their admissions policies.

Read them; they are very good.

I do not like the Bakke decision, and I will not tell you why.

But read.

—F.C.

HERE WE ARE NOT AFRAID
TO TRY THINGS

A doctor once said of his famous hospital, Here we are not afraid to try things. How beautiful that sounds. When I was younger in anesthesia, I once administered intravenous ether, I gave a spinal while crouched on the floor, through a hole in the orthopedic table, and I once put down a two-foot endotracheal tube and I remember giving anesthesia for cholecystectomy by running the tracheal catheter just into a can half full of ether that had holes punched in it and oxygen running in, so that I could deepen and lighten the anesthetic by putting my fingers on the holes and taking them off. Those days are gone, for me and for medicine.

Trying things is not easily done now. Now we have consent and informed consent, and trying new things on people is not done without soul-searching. Even monkeys and dogs are watched over in the laboratory. Trying things and teaching went together, and did we not distinguish between ward and private patients? Those who paid little

or nothing were happy to be included in grand rounds, and today we stop at all the beds if the illnesses there lend themselves to teaching.

It is necessary that we try things. But that we are not afraid is less noble than it sounds; was the *patient* afraid? Earlier experiments were done on an *inferior servant* and on a *malefactor*; there are no inferior servants and we do not experiment on prison inmates. Is progress to slow down? Will new rules be thrust upon us?

Let us grow, let us learn to treat our patients better. And somehow, let us try things.

—F.C.

THINGS THAT GROW ON YOU

Things that grow in you, parts of you that grow the way you don't want them to grow, never cease to mystify us, and this is shown by the many names we have given them, as if to say that we are baffled by their protean appearances, that we are not sure of them, and that they mystify us. And this is what we call them.

Tumor.

Newgrowth.

Cancer.

Mass.

Space-occupying lesion: we owe this nonsense to the neurologists and their surgeons.

Neoplasm.

Tumor mass: here is another beauty.

Growth.

Malignancy.

Carcinoma and sarcoma and so on.

Malignant growth.

We need one word that will mean and replace all these names, a thing that grows inside of you, out of your own cells, that is bad for you. We must invent a new name, or choose one of those already in use, and discard all the others. It would help the patient, it would make for better understanding and communicating, and it would be good for us.

—F.C.

IT'S A FREE COUNTRY

What a wonderful phrase it is: *It's a free country*. And how lightly we take it; how quick we are to repeat it without thinking, until we are brought up short by someone who has come here from a lifetime spent where there was no freedom. I have known a grocer to raise the price on something for which he did not pay more, because the price was *going to go up* on these things, but he had not yet paid the increase; but doctors are not that free.

Lawyers charge according to the contingent fee system, which is regarded as deplorable in England, but doctors who tried it right here, fifty years ago, were scolded and stopped by other leading physicians; they were told they were being too business-like.

Refuse pickeruppers strike and leave us to disease, police strike and we are alone without protection, firemen stop work and we have fires, but we may not all go off duty as others do. I may not sue my tailor for malpractice, but he can sue me. We are a minority, and a beleaguered one. It's a great life and it's a free country and we are all created equal; only some are more equal than others.

—F.C.

Physician First of All

First Frank H. Tanner Memorial Lecture
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RICHARD E. PALMER, M.D.
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I consider it a signal honor, and a particular privilege, to present this First Memorial Lecture in remembrance of Frank H. Tanner, M.D. It is a signal honor because he was a beloved husband and father, and a warm friend to many, not least to his fellow health professionals. And it is a particular privilege for me, personally, to deliver these remarks, first because he exemplified the finest traditions of the specialty we shared, pathology, and second, because he was a fellow worker in the vineyards of organized medicine. Furthermore, his commitments to medicine, and to this organized medical federation, serve as examples for all of us. Examine with me, then, certain parallels between the contributions made by pathology, this federation, and individual physicians like Dr. Tanner.

We sometimes forget that the specialty of pathology as we know it today is a comparatively recent development. It's true that to the extent that basic pathology is the study of disease, it is as old as medicine itself. But it was not until the turn of this century that pathology grew into the trunk of the modern medical tree. This has resulted from advances such as those in microbiology, biochemistry, genetics, pharmacology, and radiobiology, not to mention anatomy.

Today, of course, pathology is the basic medical science, serving as the introduction to clinical medicine, the laboratory of everyday medical practice, and the anteroom for medical research. So it is that Dr. Fielding H. Garrison, in his now-classic textbook, **The History of Medicine**, first published in 1929, said:

"The teaching of medicine as a science, as something of larger scope than its practice, began with the foundation of laboratories, and with the gradual assemblage of specialties, as units in university instruction."

Among those physicians who helped foster this growth was the reknowned William H. Welch, who in 1886 was appointed Director of the Pathology Department at Johns Hopkins University Hospital, then newly-constructed. Dr. Welch played a leading role in revolutionizing the teaching of pathology in this country.

And in the 1890's and thereafter, Dr. Welch, along with William Osler, Howard A. Kelly, and William S. Halsted, became the "big four" in the development of modern clinical teaching at Hopkins, a model emulated by medical schools throughout the nation. It was upon this firm foundation that the edifice of U.S. medical education was built following publication of the Flexner Report in 1910. And the AMA did a great deal to secure this transformation in medical education. To quote Garrison's **History of Medicine** once again:

"The (AMA's) Council on Medical Education has . . . done much to decrease the number of low grade medical schools and consequently of incompetent and unscrupulous physicians. It has also done much to secure four-year courses and 'full time' professors for the more scientific disciplines."

Thus, it was our own profession, led by organizations such as the medical schools, our federation, and the specialty societies, which started American medicine on its steady climb toward excellence. And it was the support of thousands of physicians like Dr. Tanner who have made that climb possible, and who have assured American patients of the best kind of medical care.

As Dr. Frank Cole, the Editor of the Nebraska Medical Journal, pointed out a year ago, Dr. Tanner himself was a pioneer. He was appointed as the first pathologist and Director of Laboratories for the hospitals of Lincoln in 1943, and he became both a

teacher and practitioner of pathology. Thus Dr. Tanner did much to enrich his own specialty, as well as the practice of medicine in Lincoln, and throughout the state. But other, primarily non-clinical problems have developed.

Modern medicine has assumed complex, new economic, social and political dimensions, posing problems which defy easy diagnosis and treatment. And our profession must be willing to resolutely confront, and sincerely attempt to resolve, these larger social questions. We can best do these things through our federation of state and county medical associations, and the AMA, the only organization capable of representing all physicians, no matter what their specialty or where they practice. And here, too, each physician must be willing to support our federation in pursuing its goals.

Certainly Dr. Tanner provided that kind of support through the years, and served not only as President of his county medical society, but as the 100th President of this state medical association as well. In short, as both clinician and citizen, Frank Tanner understood what it meant to be "Physician First of All" — a physician able to recognize social as well as medical responsibilities, a physician willing to stand up and be counted on behalf of his profession, and this federation. Just such physicians have made it possible for the AMA to fulfill its basic credo, adopted in Philadelphia 130 years ago, which is to promote the art and the science of medicine, and the betterment of public health.

For instance, even before the turn of the century, and the revolution in medical education which followed, the AMA prompted many public health improvements now taken for granted. They include sewer systems and pure water supplies, public health education programs, and the establishment of state boards of health. In 1895, the Journal of the AMA editorialized against the pollution of lakes and rivers in the U.S. And in the decades after 1900, the AMA endorsed public health measures such as pure food and drug laws, the fortification of milk and other foodstuffs, and the use of mass immunization programs.

Or I could cite some of the many other ways in which today's AMA still resolutely follows its founding pledge. Within the past two decades or so, we have made many positive contributions in the continuing battles against VD, drug abuse, and alcoholism. We have encouraged public health and safety measures such as the use of auto seatbelts, better health education programs, and mitigation of the pollution of our environment.

Within the past few years, we have initiated or supported programs to upgrade health services for the emotionally ill, for the prison inmate, for the alcoholic, for the American Indian, for the migrant worker, for the rural dweller, and for the inner-city resident. Within the past few months, the AMA's crusade against excessive violence on television has earned nationwide attention.

And just last December, AMA delegates met **once more** in Philadelphia, for the 1976 Clinical Session. And they followed the pattern set in that same city 130 years ago, in 1847. The House reiterated support for programs to better educate the public to the hazards of smoking, and pledged to cooperate with other concerned segments of our society toward that end. The House recommended that federal reimbursement policies be revised to encourage the use of hemodialysis in the homes of patients. And the House supported the universal usage of auto safety belts.

Now what I've given you is just a brief summary of the multitude of positive actions taken by this federation of ours. I have not touched on our other contributions to the art and the science of medicine, such as the doubling in the number of CME courses offered by the AMA within the past three years, such as AMA-ERF guarantees for about \$75 billion in medical student loans since 1952, or the unrestricted gift of about \$25 million to our medical schools. I have not talked about our recent testimony before Congress, in which we have supported a number of positive programs or proposals such as those: to continue federal grants to medical schools and for the training allied health professionals; to improve emergency care in local communities; and to upgrade

medical services for mothers and children, and for crippled children.

Nor have I talked about the fact that today just about every segment of our medical family has input into the deliberations, policies and programs of the AMA. In addition to representing physicians from the 50 states and various trust territories, our House of Delegates also represents: specialists as well as generalists, the medical schools, students, interns and residents, military physicians, and the hospitals. And, as I pointed out earlier, no other organization is capable of representing such a wide diversity of health professionals.

Parenthetically, it is only through our

federation that American physicians, as a **whole and unified profession**, can fulfill our traditional obligations to the profession, and to the public. And every single physician in this country **has** those obligations. Because every single one of us, both professionally and personally, enjoys the priceless gifts that medicine bestows.

This magnificent bequest was handed down to us by the thousands of physicians who have gone before, including Nebraska's Frank H. Tanner. And by Heaven we must hand it down to the thousands who will come after. Each of us, too, must be "Physician First of All." So let each of us, and all of us, see to it!

Thank you.

Cost of Medical Care and What We Can Do About It

THERE is a great deal being said and being written every day regarding the increasing costs of medical care. The exaggeration goes from the skyrocketing costs of medical care, to the catastrophic costs of medical care, and more recently stratospheric costs of medical care. The cost of medical care increasing is not questioned, however, the reasons for this are not clear-cut. Physicians are castigated and blamed for the increasing costs simply because they do order the tests being done. It is estimated that a new physician moving into a community will generate about \$250,000 costs in a year for medical care. Actually, there is nothing wrong with this. He is taking care of more people than were taken care of before; however the Government, Socialists et al tend to blame the physicians for this, as the primary factor and say it is bad. We know the many reasons for increasing costs. Physicians are able to take better care of patients and do a better job. New techniques, expensive equipment, proliferation of tests, higher pay schedules in hospitals, increasing costs of supplies, food, insurance, the increasing minimum wage, and greater use of paramedical people all increase the costs.

DAN A. NYE, M.D.

The Hospital Cost Containment Plan of the Federal Government actually penalizes hospitals for doing good work and keeping costs down.

I think the Nebraska Medical Association through its delegates to the AMA had a very good resolution passed at the last AMA meeting in June to identify and pinpoint actual causes of increasing costs. This study should really bring out where the costs lie so the Federal Government can shoulder its share of costs for which physicians are being blamed. If you have looked over the copies of your patients' random hospital bills which have been sent to you, aren't you astounded at the costs for certain procedures? Pulmonary functions, respiratory therapy, blood gases, anesthesiologists assistant fees, radiology fees, and some laboratory fees. The Cost Containment Committee of the Buffalo County Medical Society has been attempting to get copies of these various charges from the

hospital for various services, i.e. laboratory and x-ray charges, room charges, respiratory therapy charges, operating room charges, recovery room charges, intensive care charges, etc, but so far, the results are slow in coming. The Administrator is reluctant to give these out. He wants to talk and explain to the Society before he does so. One physician who has been trying to get these charges outlined in an Omaha hospital, is having difficulty. The administrator there does not care to give these charges to be posted. We think if these were posted at the various nursing stations, physicians would be made more aware. Some of the doctors are interested in holding down costs and will order a sodium or potassium instead of the electrolyte profile, or will order a renal profile instead of several single renal function tests, and in this way, hold down costs, but there are many of us who have no idea of what these costs are. We are creatures of habit and will order what we have been doing through the years without regard of what they cost. But for those doctors who are really interested in controlling cost and are concerned about the cost of medical care and want to do something about it, there is a vehicle through the Blue Cross-Blue Shield Physician Voluntary Cost Containment Agreement which will help control costs. It should be publicized that physicians are interested in participating in this agreement to hold down costs. This Voluntary Health Plan Agreement simply says the physician hereby agrees to accept such amount as he usually charges as his usual fee, as payment in full for covered services rendered, and will make no additional charge to Blue Cross-Blue Shield or to the patient for such covered services unless they are specifically agreed upon before the billing or before the procedures are done. Or in case of special procedures, they can be billed for more if there are certain specific circumstances that are justified and explained to the insurance company. It goes on to say that if there are complaints or controversies arising, they can be negotiated through the Nebraska Medical Association Peer Review mechanism, or, at the option of a physician, to a committee of three physicians, one that is appointed by Blue Cross-Blue Shield, one by the physician

and one by the two appointees. The final decision will be either by Peer Review or by committee, whichever, the decision will be binding by both parties.

This whole plan does not involve a really big segment of medical practice, maybe 20-25%. These agreements are the usual and customary type contracts with big companies.

Many of the physicians I have talked with feel such a program is worthwhile and should be implemented. There are those who feel animosity towards Blue Cross-Blue Shield for various reasons and will not participate, and there are others who feel that if Blue Cross-Blue Shield would have one geographic area rather than being separated from Omaha and Lincoln, they will be willing to participate. They do not like the idea of charges for various services being less out-state than in Omaha and Lincoln when their expenses are the same or greater. However, they do understand these charges can be profiled upward over a period of time if their fees are raised.

I suppose my personal opinion is that I am concerned about the future and how the Government, Socialists, Health Planners, and others are reacting. For fee-for-service contact or the fee-for-service practice of medicine is not one to contain costs. More and more is written about those alternative plans to control costs, such as the HMOs which penalize physicians for admitting patients to the hospital and award them for not admitting patients to the hospital. And just recently, a peer review system has been proposed that would incorporate the sharing of financial risks among physicians, hospitals, insurance companies, and the patient. This is really a scary alternative, even frightening, as a matter of fact. For example, if Peer Review found the hospital stay to have been unnecessary, the cost of that service could be split as follows: $\frac{1}{4}$ to be paid by the patient, $\frac{1}{4}$ to be paid by the attending physician, $\frac{1}{4}$ by the hospital, and $\frac{1}{4}$ by the insurance company. The justification for having the doctor bear part of the cost is obvious. He is the one who made the assessment that the service was required. The same reasoning can be applied for ordering laboratory pro-

cedures, x-rays, pulmonary therapy, etc., and declared unnecessary after the fact. The patient is made to share in the cost to reflect that he is not a passive figure in the relationship. Each person even if relying heavily on another's judgment must bear some responsibility for his decisions and actions. The hospital is made to share because it is supposed to have an effective utilization control mechanism which would have advised against the hospitalization either on the preadmission or a current review basis. Finally, the insurance company must bear some part of the risks, because it has a responsibility for making information on coverage readily available to the physician and the patient so the physician can make intelligent recommendations for treatment.

For these reasons, I am suggesting the members of the Buffalo County Medical Society, in fact members of the Nebraska Medical Association and even those who are not members sign this Physician's Voluntary Health Effectiveness Agreement and return it to Blue Cross-Blue Shield. Then publicize that the Buffalo County Medical Society and/or The Nebraska Medical Association Physicians are aware of the increasing costs of medical care, and are aware something needs to be done about it, are aware they have a responsibility to help keep these costs down without compromising quality of medical care. Let the news media know we are doing something about it. Not necessarily mentioning any insurance companies, but we are agreeing to accept certain fees to hold costs down.

Implications of the Bakke Decision for the University of Nebraska College of Medicine

THE University of Nebraska College of Medicine does not apply a quota system with respect to ethnic minorities or women in its admission process. However, because we are a state tax supported institution, virtually all of our students are residents of the State of Nebraska. There is no law or written legislative or regental mandate establishing this policy. However, since we have an excess of well qualified applicants who are residents of the State of Nebraska, we are able to fill our classes without assigning any weighting factor to Nebraska residency.

The Supreme Court's decision in the Bakke case was split five to four on two major issues. The principal decision was written by Justice Lewis F. Powell, Jr. He concluded that the University of California at Davis special admissions program which established a quota, "... involves the use of an explicit racial classification never before countenanced by this court." As such, it

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disregarded the individual's rights as guaranteed by the 14th Amendment. On the other hand, the California's court's judgment which enjoined the University from any consideration of race was set aside because, "... the state has a substantial interest that legitimately may be served by a properly devised admissions program involving competitive considerations of race and ethnic origins." This complex decision has been interpreted to mean that race may be considered as one of a number of plus factors in considering a given applicant, but it cannot be the major or sole factor. Many university administrators feel that the Bakke ruling does not provide clear cut guidelines and could provoke litigation for years to come from unsuccessful applicants. The reasons for such feelings are expressed in the

opinion of former U.S. Solicitor General Robert Bork, now a Yale School Law Professor. He stated that the Supreme Court, "... doesn't tell us how much race counts. We are told that we can count race somewhat but not too much. That's going to be difficult to apply."

In my opinion, one part of Justice Powell's decision which did not receive as much publicity is of major importance to all universities. "The freedom of a university to make its own judgments as to education includes selection of its student body." A university must have the right to determine its own admission process to achieve the educational goals of the institution. One of these goals may be a diverse student body reflected by varying ethnic, cultural, geographic or socioeconomic backgrounds." I interpret this portion of Justice Powell's decision to indicate that these or other factors can be employed as long as no single factor excludes consideration of a given student.

The Admissions Committee of the University of Nebraska College of Medicine considers a number of factors, some objective and some subjective, in evaluating an applicant: College performance including such things as grade point average, the difficulty of the course work, and the college attended; aptitude as reflected by MCAT scores;

letters of recommendation; psychological characteristics necessary to be a good physician reflected by summer and volunteer work, indicating an interest in health and people, and by personal interviews. In the last few years the College, as have other medical schools throughout the country, has placed special emphasis on the recruitment of minority students; however, no quotas have been established. All applicants have been judged against established criteria and all students admitted met or exceeded these criteria.

It has been suggested that an increase in the number of rural physicians could be brought about by admitting more students who were raised in rural areas to medical school. Assuming this to be true, the admissions process of the College of Medicine could respond to the need for more physicians in rural Nebraska by considering the geographic origin of an applicant as a plus factor in the admissions process. However, it appears clear that the Bakke decision would not allow the College of Medicine to establish a quota which would set aside a given number of positions in the class for individuals who were raised and educated in rural Nebraska.

In conclusion, I believe that the present admission policies of the University of Nebraska College of Medicine are not in conflict with the Bakke decision.

Admission to Creighton University School of Medicine

THE number of inquiries we receive concerning the requirements for admission to the Creighton University School of Medicine seems always to be at a high level. Recently this interest has intensified as a result of the decision handed down by the Supreme Court in the celebrated Bakke case. Perhaps a review of pertinent features of our admissions program would be timely.

The following paragraph from the **Bulletin** of the School gets to the heart of the matter:

"Fulfillment of the specific requirements does not insure admission to the School of Medicine. The Committee on Admissions will select those applicants whom they judge to be best qualified for the study and practice of medicine. In evaluating the applicants, consideration will be given to all of the qualities considered to be necessary in the physician. Intellectual curiosity, emotional maturity, honesty, and proper motivation, in addition to proven scholastic ability, are of the utmost importance."

In carrying out its responsibility, the Admissions Committee of 14 members of the basic science and clinical faculty, full time and volunteer, does not use any rigid criteria to define academic and other qualifications. Applications from candidates with QPAs of under 3.0 (on a 4.0 scale) and MCATs under the 50th percentile are actively discouraged but in no way are they summarily discarded. In actuality, and citing the August 1977 class as typical, the cumulative GPA of our entering students was 3.44 and the mean MCAT scores were above the 50th percentile in all categories.

It is apparent that the admissions process is not, nor can it be, totally objective. In fact, we believe it should not be if the unique mission of the school is to be fulfilled. In addition to the factors of character and personality cited above, Creighton grants preferential consideration to **qualified** applicants from our own preprofessional programs, from Nebraska and contiguous

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states, from states without medical schools, and to applicants with a close family relationship to an alumnus of our school. A four-year-old contract with the State of Wyoming assures acceptances to at least 20 qualified applicants from that state in each entering class.

Finally, in the last decade, Creighton has joined America's effort to increase the opportunity for a professional education for members of ethnic minorities underrepresented in the professions through direct or indirect discriminatory practices. We make special efforts to attract applications from **qualified** members of these groups, and, where there is substantial evidence the applicant's potential has not been fully developed, opportunities for development of that potential are made available. These opportunities take the form of postbaccalaureate preparatory programs and summer enrichment programs.

Our entering class is not formed with the use of any kind of quota system, not for our own undergraduates (who comprise the largest single homogenous group) nor for the educationally disadvantaged. And by this I mean there is no maximum number of applicants from any identifiable group that will be accepted, nor is there any minimum number. This, of course, excludes our contract students from Wyoming. The result is an interesting and wholesome mix. The 1977 class, for example, included 41 from our own University, 21 from Wyoming, and 11 minority students. The 110 students were from 25 states and one foreign country.

It should be clear that even with a declining number of applications (7766 in 1977 and 6705 in 1978) the number not accepted will include a significant percentage of candidates who are qualified by any reasonable standard. Whether or not they are **more** qualified than those accepted is beyond the ken of any mortal.

Cross-Sectional Echocardiographic Diagnosis of Left Ventricular Aneurysm

ABSTRACT

A large inferior wall left ventricular aneurysm was clearly visualized by cross-sectional echocardiography, but was not clinically suspected, and was not demonstrated by standard M mode echocardiography. This case emphasizes the usefulness of cross-sectional echocardiography, which is probably the most sensitive noninvasive method to diagnose ventricular aneurysms.

MODE echocardiography is limited by the fact that a single "ice-pick" view is obtained from a single transducer. This is a particular drawback in coronary artery disease where ventricular function and wall motion are frequently abnormal in a non-uniform way. For these reasons, standard M mode echocardiogram have been less than satisfactory in demonstrating left ventricular aneurysms.

Real time, two dimensional, cross section echocardiography has recently become available and may resolve some of these difficulties. The Varian system is dependent upon a 1.2 cm transducer array composed of 32 precision mounted piezoelectric crystals in tight linear array, which through micro-processor control, scans an 84° fan-shaped body cross section at a rate of 30 times per second. Real time imaging allows structures to be seen in their true instantaneous anatomic relationships, and the structures can be rapidly screened for localization of areas of interest.

A large left ventricular aneurysm complicating acute inferior wall myocardial infarction associated with ventricular septal rupture is reported. This large aneurysm was clinically unsuspected, was not demonstrated by standard M mode echocardiography, but was clearly visualized by real time cross-sectional echocardiography.

CASE HISTORY

51 year old white female developed an acute inferior myocardial infarction on

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4/10/77. Signs of congestive heart failure developed over the next three weeks. She was transferred to the University of Nebraska Medical Center on May 3, 1977, because of poorly controlled congestive heart failure and a new loud systolic murmur.

Physical examination on admission revealed an ill-looking, dyspneic patient. A right ventricular lift was palpable but no consistent thrill was felt. A Grade III/VI pansystolic murmur was best heard at the lower left sternal border and apex with wide transmission. A prominent S3 gallop was present. Examination of the chest showed bilateral pleural effusions and wide-spread rales.

Chest x-ray showed generalized cardiomegaly with pulmonary congestion and bilateral pleural effusions. EKG showed sinus rhythm with evolutionary changes of transmural inferior wall myocardial infarction. An M mode echocardiogram was technically difficult and was inadequate for purposes of accurately evaluating left ventricular size and function although interventricular septum appeared hyperkinetic. No definite aneurysm was seen. A Varian two dimensional echo showed excellent motion of the

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anterior wall and apex of the left ventricle; however, a large posterobasal aneurysm was clearly demonstrated (Figure 1).

She subsequently underwent cardiac catheterization by the Seldinger percutaneous technique on 5/17/77. Right heart pressures were mildly elevated. The pulmonary capillary wedge pressure and left ventricular end diastolic pressures were moderately elevated. Shunt calculations revealed a systemic flow of 3.5 L/min with a pulmonary blood flow of 6.7 L/min, giving a $QP/QS = 1.9:1$.

A biplane left ventricular cineangiogram revealed a large aneurysm occupying the lower septal and inferior surface of the left ventricle plus a inferobasal ventricular septal

defect. This displaced the cardiac silhouette superiorly and gave a bizzare left ventricular contour, invalidating left ventricular volumes (Figure 2). There was 1+ mitral regurgitation. The anterior wall of the left ventricle contracted vigorously. Selective injection of the coronary arteriography showed a 100% obstruction of the midright coronary. The left main, left anterior descending and left circumflex vessels were all free of significant obstructive disease.

She was taken to surgery on 5/21/77 (5½ weeks postinfarction). Several hundred milliliters of blood were removed from the pericardial sac. A large left ventricular aneurysm was resected and a low muscular ventricular septal defect was closed with a teflon felt patch from the left ventricular

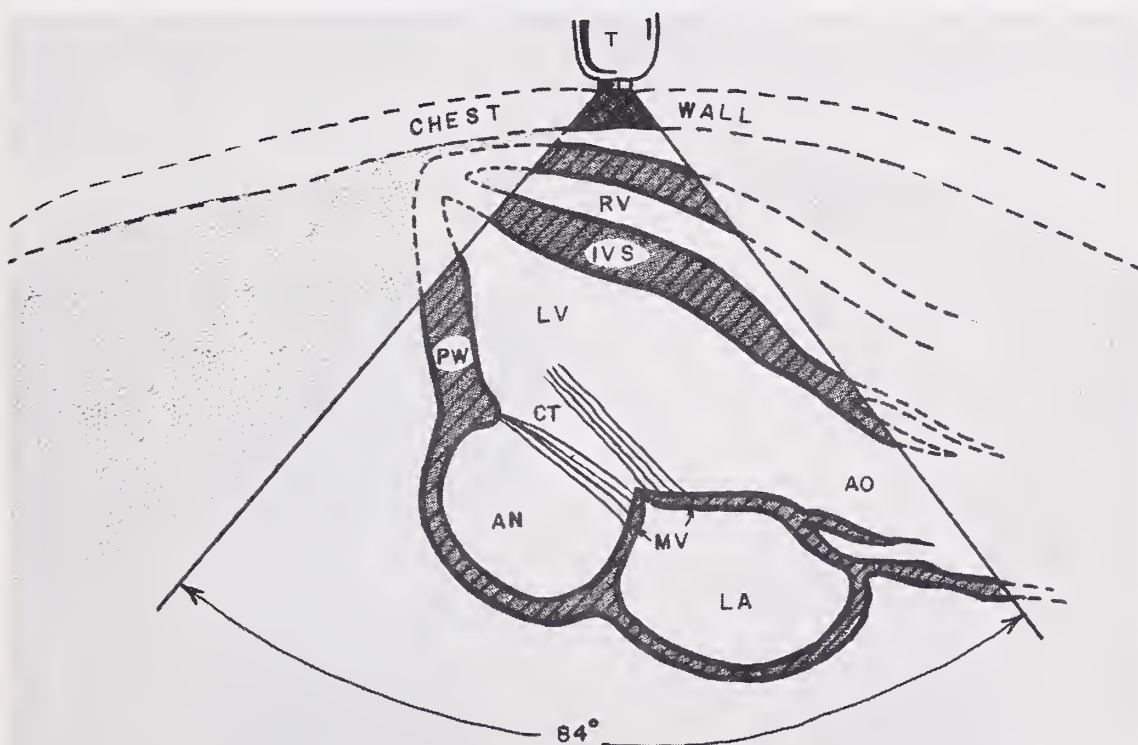


Figure 1a

Schematic diagram of cross-sectional echocardiogram of left ventricle. Basal-inferior wall left ventricular aneurysm is noted by abbreviation AN.

Abbreviations:

- T — transducer
- RV — right ventricle
- IVS — interventricular septum
- LV — left ventricle
- PW — posterior wall of left ventricle
- CT — chordae tendineae
- MV — mitral valve
- LA — left atrium
- AO — aorta



Figure 1b

Actual cross-sectional echocardiogram of left ventricular aneurysm on the basal-inferior wall. EFF - posterior pericardial effusion.

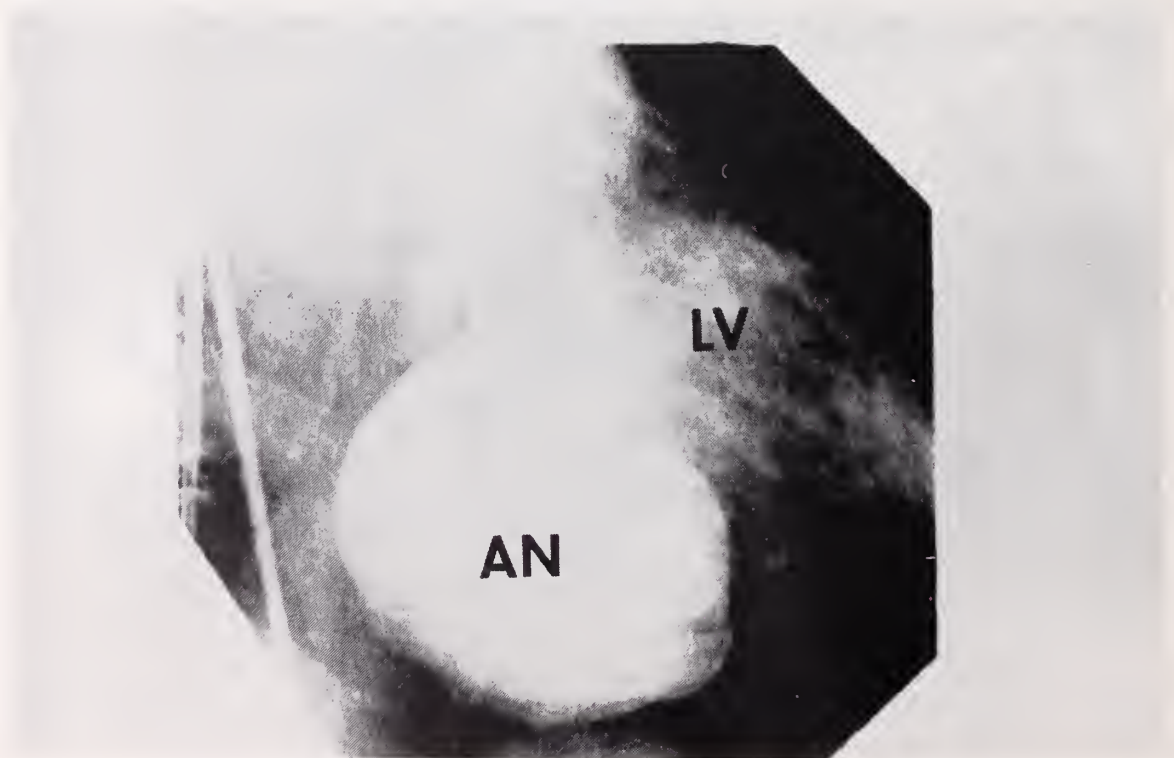


Figure 2

Left ventricular cineangiogram in the right anterior oblique projection. The very large inferior wall left ventricular aneurysm is noted by AN.

side. Her subsequent postoperative course was uneventful, and she was discharged on the tenth postoperative day.

DISCUSSION

This report emphasizes the diagnostic usefulness of cross-sectional echocardiography in detecting left ventricular aneurysms. The M mode scan did not raise the question of a left ventricular aneurysm. This is due to the inherent limitations of the M mode scan which obtains information from a single crystal over a narrow ultrasonic beam.

Previous M mode echocardiographic case reports have shown the ability to diagnose a left ventricular aneurysm if they predominantly involve the posterior wall. In this situation a localized prominent displacement of the posterior wall may develop.^{1, 2}

Dillon et al noted that the apical LV dimension by M mode exceeded a more basal LV dimension in 17 of 18 patients undergoing surgical resection of a ventricular aneurysm. However, the diagnostic ability of M mode echo was not evaluated since all cases were preselected, i.e. going to surgery.

Two reports have indicated that localized areas of asynergy could be detected by B mode scanning.^{4, 5} We have had no experience with this technique for the heart.

Weyman et al, recently reported their results in 31 patients with angiographically proven LV aneurysms.⁶ In each case the presence and location of the aneurysm was visualized by a 30° cross-sectional scanner. M mode echo was abnormal in 14% of 30 (47%) and only in patients with anteroapical aneurysms. When comparing cross-sectional echocardiography to the physical exam, chest x-ray, ECG, and M mode echo, there were eleven patients in whom ventricular aneurysms were only detected by cross-sectional echocardiography.

It appears that cross-sectional echocardiography is now the most sensitive non-invasive method to diagnose the presence or absence of ventricular aneurysms.

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Due to an error in the continuity of this article which appeared in the October 1978 issue of the Nebraska Medical Journal, it is being printed correctly in this issue. The publisher regrets the mistake and wishes to apologize to the following: John F. Aita, M.D., the author, Frank Cole, M.D., the editor, the Medical Journal Staff and all the subscribers for any inconveniences caused.

Cranial Computerized Tomography and Chronic Multiple Sclerosis

ABSTRACT

The cranial computerized tomography appearance of long standing cases of multiple sclerosis is one of atrophy with compensatory enlargement of ventricles, fissures, cisterns, and sulci.

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THE cranial computerized tomography (CT) appearance of multiple sclerosis is well established and is related to the size, location, and age of the demyelinating process.¹

In chronic cases of multiple sclerosis, cranial CT demonstrates atrophy which is characterized by enlargement of ventricles, fissures, cisterns and sulci.²⁻¹⁰ Neuropathologically, this atrophy seen in long standing cases of multiple sclerosis is felt to be due to shrinkage of the white matter secondary to

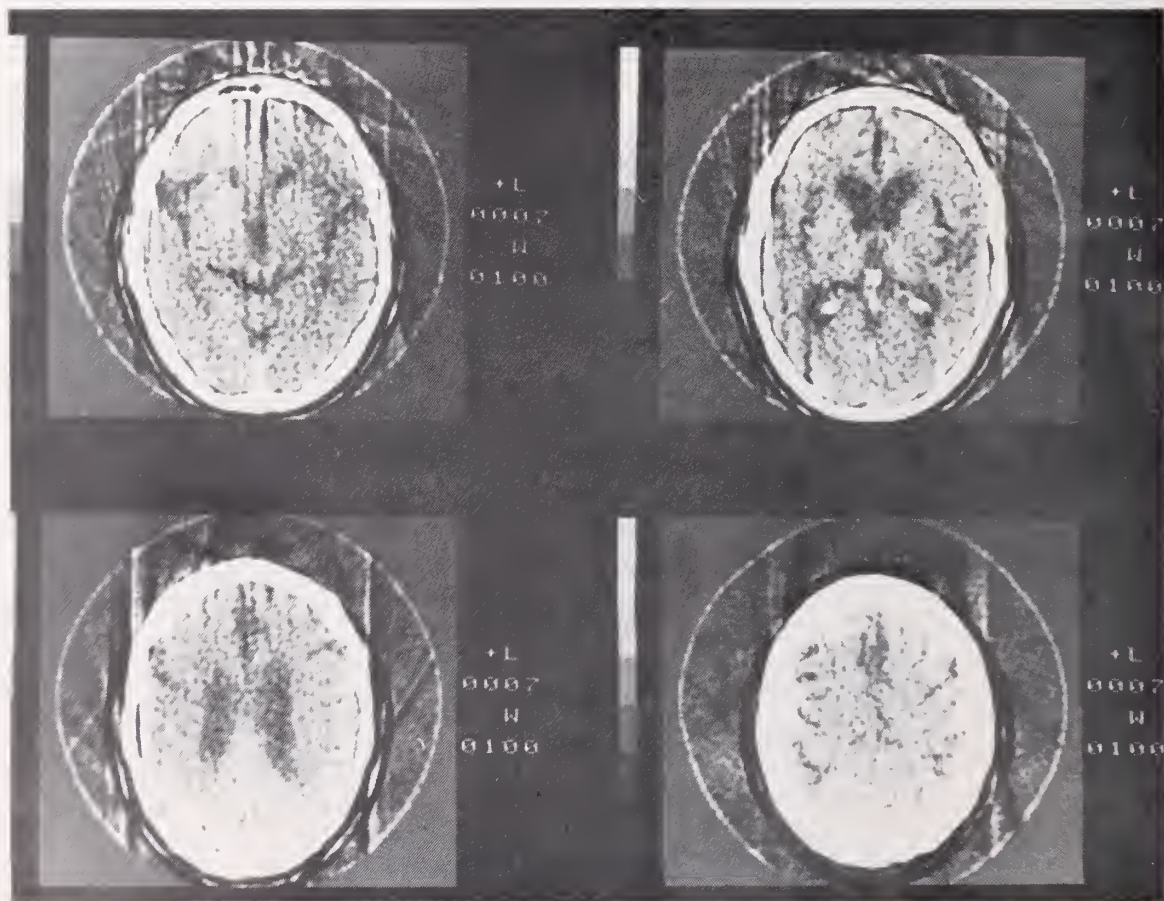


Figure 1

45 year old male with documented multiple sclerosis of 18.5 years duration. Cranial CT evidence of diffuse atrophy with enlargement of both lateral ventricles, third ventricle, right and left Sylvian and anterior inter-hemispheric fissures, cisterna ambiens, and sulci.

both sclerosis and tissue loss from demyelination.¹¹⁻¹³

Figure 1 is representative of the cranial CT appearance of chronic multiple sclerosis. The patient, a 45 year old male with well documented multiple sclerosis of 18.5 years duration is shown to have diffuse atrophy with enlargement of right and left lateral and third ventricles, right and left Sylvian and interhemispheric fissures, cisterna

ambiens, and sulci. The generalized atrophy seen in this case is almost identical to that seen in a 70 year old female with dementia secondary to a diffuse atrophic-degenerative central nervous system disease process. (Figure 2).

Gyldensted^{6,7} studied 110 multiple sclerosis patients with cranial CT and found that 86 patients (78%) had evidence of atrophy

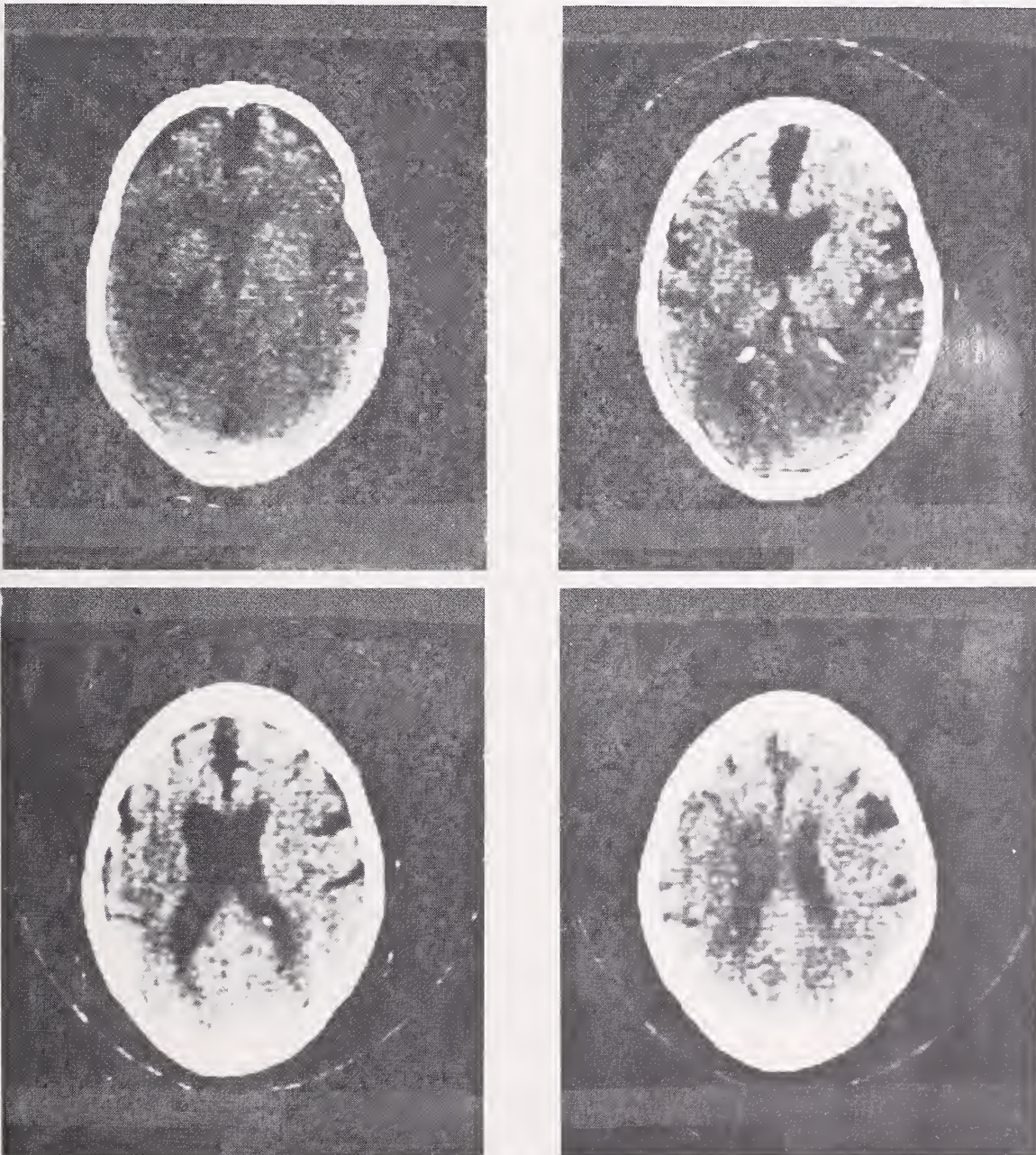


Figure 2

70 year old female with dementia. Cranial CT evidence of diffuse atrophy with enlargement of both lateral ventricles, third ventricle, right and left Sylvian and anterior interhemispheric fissures, cisterna ambiens, and sulci. [Reprinted with permission of the Nebraska Medical Journal].

with an increase in the size of the sulci, Sylvian fissures, and lateral, but not third, ventricles. Fifty of these 110 patients (45%), with an average duration of multiple sclerosis of 18.4-19.0 years, were found to have atrophy only — similar to the case represented in figure 1. Forty-one of his 110 patients (37%) were found to have periventricular low x-ray attenuation areas (probably regions of sclerosis¹⁴); of this group, 40 patients (98%) also had cranial CT evidence of atrophy.

Thus, cranial CT may be of value in the diagnosis of long standing cases of multiple sclerosis by demonstrating generalized atrophy with enlargement of cisterns, fissures, sulci, and of the ventricular system.

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*Address for correspondence: John F. Aita, M.D., Midwest Clinic, Consultants in Psychiatry and Neurology, 105 S. 49th Street, Omaha, Nebraska 68132

Down Memory Lane

1. No country in the history of the world has had so many unofficial health agencies as exist in the United States, prominent examples of which are: The American Medical Association and kindred organizations; the American Red Cross and associated agencies; the Rockefeller Foundation; insurance companies; industrial companies; fraternal orders and social organizations.

2. First of all, I think one of the reasons why we do cesarean sections is because the patient gets exhausted.

3. Time was when it was thought a physician must remain aloof from politics and attend strictly to the duties of the profession; *time is* when the physician must take part in politics in order to do his duty to himself, to his profession and to the state.

4. It has been pretty generally recognized for some time by the careful observer that

the teaching of Obstetrics in our American colleges has not been given the recognition its importance deserves.

5. The occurrence of hypernephroma is comparatively rare.

6. The incidence of syphilis in obstetrical patients at the University of Nebraska College of Medicine is 5.5% ; a few per cent lower than the average of 8.3% as reported by the subcommittee of the Medical Women's National Association, comprising figures from 15 clinics who were able to furnish statistics in 6,300 patients.

7. Public Health takes precedence over all other functions of government.

8. Ulm passed an ordinance against smoky chimneys in 1427.

Nebraska State Medical Journal
November, 1928.

President's Page

WHY DO YOU DO IT?

As the CBers say, "Mercy, Mercy." Some of us reared in strong conservative Germanic homes have a number of more appropriate expletives.

These terms may be used singly, in pairs, and sometimes in phrases. No matter how you put them together they are satisfying to the soul when speaking broadly of HEW, various and sundry bureaucrats, don't forget the FDA, and OSHA. They have spawned such marvelous programs as medicare, medicaid, PSRO, utilization review committees, second surgical opinions, HSAs, HMOs; they are not content — now we look to NHI and some of the other beauties bound to create fiscal suicide.

You put up with high taxes, continuous assaults from the news media and congress, you deal with the CPI, lobbyists, generics, mountains of legislation and insurance forms, why Aunt Mary really doesn't have the same exotic disease that Pretty Polly on the soap opera has — you listen and read of the contrived doctor shortage, all of the "fun" central planning things, try to avert laws allowing trash like laetrile to be used.

Do you do this for prestige? Probably not! Somewhere along the line something called professionalism crept in. The early morning rises from bed — the long hours, the long



days, and all of the above still do not seem capable of tipping the scales away from that diagnostic challenge, the demonstration of surgical skills and judgment, the therapeutic triumphs, AND the GRATEFUL PATIENT.

Houtz Steenburg, M.D.



The Auxiliary

TAKE IT TO HEART...

Over 600,000 people die annually from cardiac arrest. 400,000 of these are out-of-hospital deaths and most are during the first two hours after the heart arrest.

THERE IS SOMETHING that can be DONE to help cut this number of deaths by about half.

CPR (Cardiopulmonary Resuscitation) or Basic Life Support, is the LIFE SAVING TECHNIQUE anyone can learn and perform to provide artificial breathing and circulation for the person with a cardiac arrest of whose breathing mechanism has stopped.

CPR DOES SAVE LIVES and from *any cause of cardiac arrest or breathing stoppage* such as: downing, electrocution, drug overdose, allergy reactions, suffocation, choking, strokes and *not just heart attack*.

It takes 5-6 hours of your time to learn Basic Life Support. Such a small amount of time, especially if it has allowed another person to resume his or her life, THANKS to your efforts of performing CPR! REMEMBER "the life you save may be one of YOUR loved ones." Cardiac arrest can happen to any of us at any time.

If your County is interested in CPR Training, contact your local Heart Associa-

tion, or if you live close to Lincoln, some of the Lancaster County Medical Auxiliary members would be glad to train your members.

It is highly recommended, if possible, to have some of your members trained to be Basic Life Support Trainers. This way you can have a continuous program of training in your community.

Several of Lancaster County Auxiliarians have been basic life support trainers for the past 3 years. We also have 4 Instructor Trainers. The *rewards* have far outweighed the time and sometimes hectic schedules we have been maintaining, *NOT* to mention the *better public relations with the community and the medical profession*. During the past 3 years we have trained approximately 1,500 people in basic life support and another 100 to be basic life support trainers.

Please write or call me for further information or if you have any questions on how to get a program started in your county. I will be glad to help in any way possible.

Mrs. Larry (Peg) Fletcher
CPR Chairman, NMA Auxiliary
610 Teakwood Drive
Lincoln, Nebraska 68510
402-488-7942

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Goal for support from Medical Community 150,000.00*
*House of Delegate action October 1976, recommended
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70% of the \$150,000.00 has been raised
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COMPATIBILITY



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding. Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

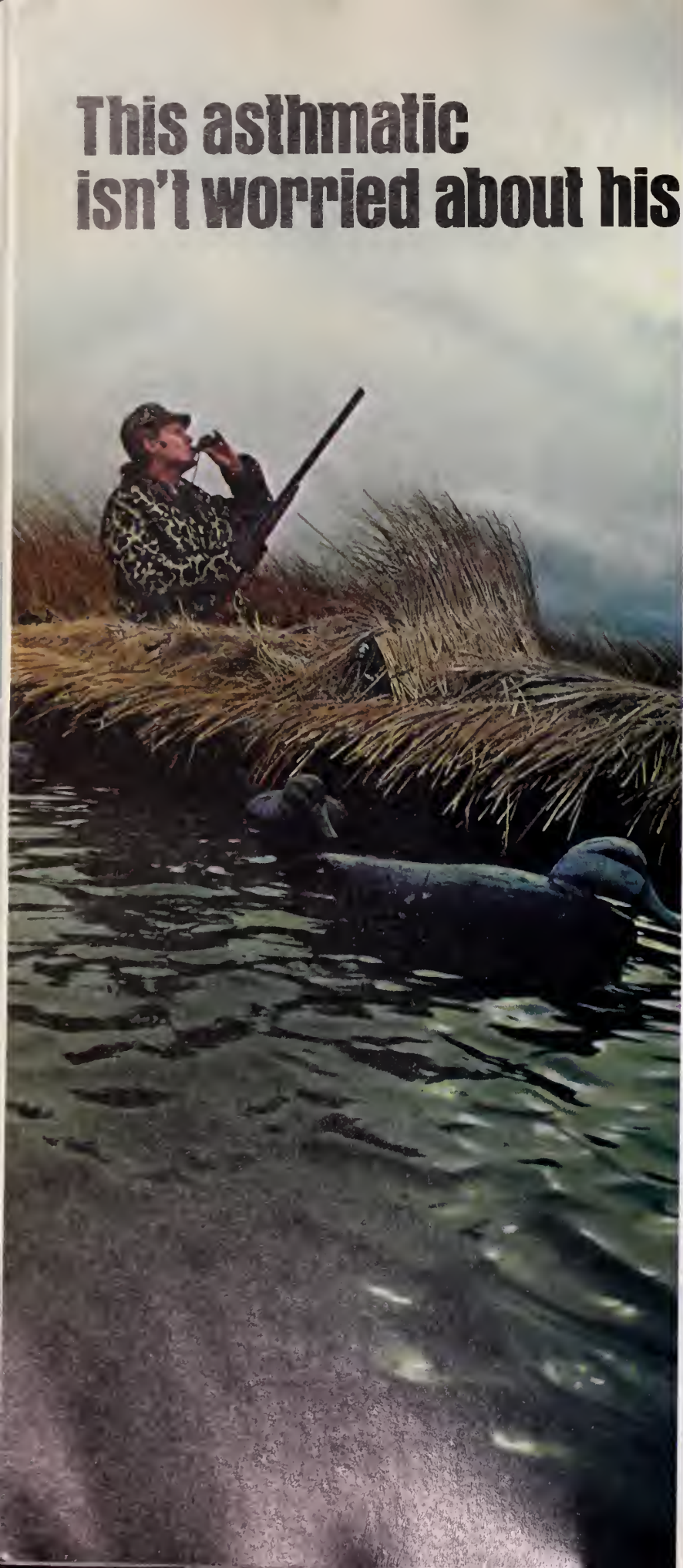
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20-mg tablets

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Each capsule or tablespoon (15 ml) elixir
contains theophylline (anhydrous) 150 mg
and glyceryl guaiacolate (guaifenesin)
90 mg. Elixir: alcohol 15%

- theophylline for effective
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- 100% free theophylline

Indications: For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema.

Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Merabolins of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 µg/ml.

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In accordance with the House of Delegates action* we give/pledge \$_____ for the development and maintenance of the Health Galleries.

Make your check payable to: The University of Nebraska Foundation

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For my pledge please send reminders _____ Annually _____ Semi-annually _____ Quarterly

★ October, 1976 Resolution for gift from each physician for \$200 to support the Health Galleries.

Between Cases

On Doing Your Thing.

The fact that you are a mental patient or that I am a doctor is purely a matter of chance.

Chekov: Ward 6.

Common Cold Cure.

A tallow candle is a wonderful remedy. At night you smear your nostrils with it and in the morning you're fit as a fiddle.

Andrei Bely: Petersburg.

The Diagnosis.

Chronic alcoholism with alcohol addiction.

Section On Walking.

The patient was ambulatory in a wheel chair.

Department Of Words.

Muscle strength.

What else has strength? Bones?

The Outcome.

He slowly snapped out of it.

On Collections.

Well knows the Educated Heart that the doctor's clients usually pay slowly, and itself therefore pays without delay.

Gelett Burgess: Have you an educated heart.

The History.

He does a lot of kneeling on his knees.

The Prescription.

I have asked him to de cease from this.

On Manners.

When a doctor is rude, it makes a person feel so healthy.

Arthur Schnitzler: Dying.

Section On Covering Up.

Doctors are not always as good at covering up as they think.

Eric Ambler: The intercom conspiracy.

Words I Can Do Without.

Ongoing, horrific, liaison, conformal, pre-ludium, cognition.

The History.

He had numbness and difficulty in voiding in both legs.

Section On Infinitives.

He was unable to hardly walk.

Department of past and future events.

Some memory deficit for past events.

—F.C.

Our Medical Schools

PONTE VEDRA, FLORIDA — Robert P. Heaney, M.D., Vice President for Health Sciences at Creighton University and member of the Board of Directors of the Association for Academic Health Centers (AAHC), was elected President-Elect of the Association during its Annual Meeting in Florida, October 7, 1978.

The AAHC, which established its Washington office in 1971 under a grant from the W. K. Kellogg Foundation, is a national education association whose membership is

composed of the chief administrative officers of the nation's university-based health centers. Reflecting the interests of its members, the Association is the only national education association which is interdisciplinary and multidisciplinary in its focus, its primary interest being total health manpower education.

Before his appointment in 1971, Dr. Heaney served as Head of the Section of Endocrinology and Metabolism, and Chairman of the Department of Medicine at Creighton University.

Coming Meetings

CRIPPLED CHILDREN'S CLINICS —

November 4 — Hartington, Trinity
Lutheran Church

AMERICAN MEDICAL ASSOCIATION —

Interim Session, House of Delegates,
December 2-6, 1978, Palmer House, Chi-
cago, Illinois.

AMERICAN MEDICAL ASSOCIATION —

Winter Scientific Program, December 7-10,
1978, Las Vegas, Nevada.

RADIOLOGY OF THE ACUTELY ILL AND INJURED PATIENT — UPDATE 1979;

January 26-27, 1979; Stouffer's Hotel,
Greenway Plaza, Houston, Texas. Pre-
sented by The University of Texas Medical
School at Houston, Department of Radio-
logy. Co-sponsored by The University of
Texas Health Science Center at Hous-
ton, School of Allied Health Sciences and
Division of Continuing Education. Fee:
\$150.00; write to: Division of Continuing
Education, The University of Texas Health
Science Center at Houston, P.O. Box 20367,
Houston, Texas 77025. This course
meets the criteria for 14 credit hours
in Category I of the Physician's Recog-
nition Award of the American Medi-
cal Association, provided it is used and
completed as designed. Application has
been made to the American College of
Emergency Physicians for 14 ACEP Cat-
egory I credits, and to the American
Academy of Family Physicians for 14
Prescribed credit hours.

NEBRASKA MEDICAL ASSOCIATION —

Annual Session, April 29 - May 2, 1979,
Holiday Inn, Kearney, Nebraska.

AMERICAN MEDICAL ASSOCIATION —

Annual Convention, July 22-26, 1979,
Chicago, Illinois.

Tenuate® 

(diethylpropion hydrochloride NF)

Tenuate Dospan®

(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression, changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSEAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release. One 75 mg tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSEAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc.

Cayey, Puerto Rico 00633

Direct Medical Inquiries to

MERRELL-NATIONAL LABORATORIES

Division of Richardson-Merrell Inc.

Cincinnati, Ohio 45215, U.S.A.

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References: 1. Citations available on request — Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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8-3921 (Y587A)

**Whether overweight is a
complicating factor...
or just uncomplicated overweight.**

Tenuate[®] Dospan[®] ^{IV} **(diethylpropion hydrochloride NF)** **75 mg. controlled-release tablets**

A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with hypertension, symptomatic cardiovascular disease, or diabetes. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. (Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.)

In uncomplicated obesity.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorexic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.¹ And the unique chemistry of Tenuate provides "...anorexic potency with minimal overt central nervous system or cardiovascular stimulation."² Compared with the amphetamines, diethylpropion has minimal potential for abuse.

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For prescribing information see opposite page



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Picture Gallery

1978 NMA Fall Session



Doctor Carlyle E. Wilson, Jr. presiding at the Board of Councilors meeting.



Board of Councilors.



Doctor Houtz G. Steenburg addressing the Board of Councilors.



Board of Councilors.



Board of Directors meeting during 1978 Fall Session.



Doctor Harry W. McFadden, Jr. presiding at House of Delegates session.



Doctors Houtz G. Steenburg, NMA President; Carlyle E. Wilson, Jr., Chairman, Board of Councilors and Charles W. Landgraf, Jr., NMA President-Elect.



Doctor Harry W. McFadden, Jr. congratulating Doctor Alvin A. Armstrong upon his election as Vice Speaker of the NMA House of Delegates.

Picture Gallery

1978 NMA Fall Session



Doctor Neal A. Vanselow, Chancellor UNMC, addressing NMA House of Delegates.



NMA House of Delegates.



NMA House of Delegates.



NMA House of Delegates.



NMA House of Delegates.



Doctor Russell L. Gorthey presenting Reference Committee Report.



Doctor Stanley M. Truhlsen presenting Reference Committee Report.



Doctor James H. Dunlap presenting Reference Committee Report.

Picture Gallery

1978 NMA Fall Session



Doctor Kenton L. Shaffer presenting Reference Committee Report.



Doctor C. N. Sorensen presenting Reference Committee Report.



Doctor F. F. Paustian presenting Reference Committee Report.

Books



The metabolic management of the critically ill; by Douglas W. Wilmore, M.D.; 262 pages; \$22.50 hard cover; published 1977 by the Plenum Medical Book Company, 227 West 17th Street, New York, N.Y. 10011.

This book deals with the metabolic and nutritional problems of critically ill patients. I could not find the words cancer, carcinoma, myocardial infarction, malignancy, or even disease in the index; it is not that kind of a book. It is divided into 5 chapters: energy and energy balance; control of body temperature, relationships with metabolic control; hormonal control of body fuels; alterations in intermediary metabolism; and feeding the patient; these are divided into and consist entirely of 183 questions and answers.

This makes for easy reading. The print is good; there is a fine index, an excellent support plan insert; and an appendix, consisting of 8 problems. There are many figures, and a generous supply of numbered references, which I like.

The questions are, you might say, basic; like How does the body store energy?, How prevalent is hospital malnutrition?, What minerals and trace elements should be provided in diets for the critically ill patient? The author's name is followed, on the title page, by: U.S. Army Institute of Surgical Research, Brooke Army Medical Center, Fort Sam Houston, Texas. I found the book interesting.

—F.C.

Books received.

Occupational diseases: A syllabus of signs and symptoms; by E. R. Plunkett, M.D.; 352 pages; hard cover, \$22.95; published 1977 by The Barrett Book Company, 388 Summer Street, Stamford, Connecticut 06901.

In Memoriam

*By medicine life may be prolong'd
yet death*

Will seize the doctor too.

—Shakespeare

Dr. Howard L. Copas

Doctor Howard L. Copas died on May 17, 1978, at the age of 49. Doctor Copas was born in Lyman, Nebraska, on December 18, 1928.

He graduated from the University of Nebraska College of Medicine in 1958.

Following 10 years in the service, he returned to Omaha in 1968 and became a partner in Nebraska-Iowa Radiology Consultants.

He was a Past President of the Nebraska Chapter of the American College of Radiology.

Survivors include his wife, Shirley; daughters, Kim and Leslie; and sister, Mrs. Walter Hodges of Arlington, Virginia.

Physicians' Classified

Advertisements in this column are run at a rate of twenty cents per word with a minimum of \$10.00 per insertion. Copy must be received by the fifth of the month preceding date of publication and should not exceed 50 words. Each advertisement will be taken out following its first appearance unless otherwise instructed. Where numbers follow advertisements, replies should be addressed in care of The Nebraska Medical Journal, 1902 First National Bank Building, Lincoln, Nebraska 68508.

MEDICAL DIRECTOR — General practitioner to perform general examination, care, and treatment of patients at state psychiatric hospital. Forty-hour week with rotating on-call duty. No surgery. Starting salary of \$41,000 to \$45,000, depending on experience. Excellent benefits. Contact: H. D. Herrick, M.D., Superintendent, Norfolk Regional Center, Box 1209, Norfolk, Nebraska 68701. Call Collect: 402-371-4343.

OPPORTUNITY IN FAMILY PRACTICE. Two Board Certified Family Physicians need third physician. New office connected to new hospital (250 beds) with all ancillary and specialized services available. Any interested physicians please sent curriculum vitae to Link, Chapman & Associates, Inc., 1515 West Truman Road, Independence, Missouri 64050, or call collect 816-836-8200; 9:00 A.M. to 4:30 P.M.

INTERNIST, 30-year-old American with four-year postgraduate training (three in medicine, one in neurology) seeks association with other internists in Omaha or Lincoln. Available July, 1979. Write: R. K. Gleeson, M.D., 711 Wheaton Road, Iowa City, Iowa 52240.

NEBRASKA: New Hospital Emergency Department ready to expand to full-time coverage. Hours Monday-Friday; no weekends. Two physicians needed for week day/night Emergency Department coverage. Excellent Income plus benefits. Contact: Box #65, NEBRASKA MEDICAL JOURNAL, 1902 First National Bank Building, Lincoln, Nebraska 68508.

PSYCHIATRIC RESIDENCY: Vacancies for PG2 through PG4 positions starting January 1, 1979, through July 1, 1979. For those eligible for an Iowa Residents License via the ECFMG receive stipends of: 1st year, \$21,294; 2nd year, \$22,360; 3rd year, \$23,478. Those eligible for a regular Iowa license via FLEX or reciprocity receive stipends of: 1st year, \$23,478; 2nd year, \$24,648; 3rd year, \$25,896. Prepare for a career in private practice, community clinics or hospital based psychiatry. Emphasis on close supervision of intensive individual and group psychotherapy, OPD, Children's Unit, Adolescent Unit. Neurology affiliation with University of Iowa. Intensity of training program appreciated best by personal visit. T. B. McManus, M.D., Superintendent, Mental Health Institute, Cherokee, Iowa 51012. Call collect 712-225-2594. Equal Opportunity Employer.

ASSISTANT DIRECTOR: Lincoln Family Practice Program. Major emphasis on teaching and supervising residents with some administrative responsibility. ABFP certified or eligible. Competitive salary and benefits. Contact John C. Finegan, M.D., Director, 4600 Valley Road, Lincoln, Nebraska 68510. 402-483-4591. Equal Opportunity Employer.

PHYSICIAN NEEDED for resort community in magnificent sunbelt setting. Enjoy superb golf, tennis, sailing, riding, fishing, hunting and all water sports. Start with a guaranteed salary and benefit package. No investment required, but in two years, you can own your own practice including medical and office equipment and office furniture purchased at book value. Benefits include liberal vacation. Study time with travel expenses paid. Paid malpractice, health, accident and life insurance. For more information, write Don Small, Fairfield Bay Medical Center, Box 3008, Fairfield Bay, Arkansas 72088, or call toll-free 800/643-9790 or 643-9791 (in Arkansas, call 501/884-6334).

11-78

WashingtonNotes

On HCFA.

The first top-level health official of the Carter Administration to topple is Robert Derzon, ousted as head of the Health Care Financing Administration (HCFA) the new agency that operates Medicare and Medicaid.

Derzon fell out with HEW Secretary Califano in disputes over policy and over organizational matters. Derzon wasn't moving fast enough to whip HCFA into shape, Califano believed. Derzon, 47, a hospital administrator, took issue with the belligerent attitude of Califano toward health providers.

Califano has been under pressure from Congress to get HCFA moving. The Agency was originally the idea of the Senate Finance Committee and was embodied in proposed legislation. Califano preempted the plan and made the sweeping organizational shift 18 months ago. Medicare had been under Social Security; Medicaid under HEW's Welfare Division.

Second opinion, & 3rd opinion.

Twenty-seven Blue Cross and Blue Shield plans will reimburse for second opinions on the need for elective surgery recommended by physicians. Many more plans are expected to be involved in second opinion surgery programs in the near future, Blue Cross-Blue Shield reported.

Under the program, all charges related to the second opinion, including the consulting specialist's fees, x-rays and laboratory tests, are covered by the plans. If the second opinion differs from the first, some plans pay for a third opinion to help the subscriber decide whether or not to have surgery.

The Blues released the statement on second opinions to coincide with the scheduled official launching of HEW's second opinion program for Medicare and Medicaid. The Government plans an extensive publicity campaign to encourage the public to seek second opinions when suitable.

In comment upon the HEW program James H. Sammons, M.D., AMA Executive Vice President, commented: "The concept of second opinions is not new to the medical profession. The AMA has for years supported voluntary consultation. The Association's Principles of Medical Ethics specifically state that, 'A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.'

Classification of diseases.

A new disease classification system for use in hospitals and related clinical settings has been endorsed by HEW. Starting next year, the system will be required in HEW-financed programs such as Medicare, the Professional Standards Review Organization program and the Cooperative Health Statistics System.

The new system, called the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), will be used to coordinate statistics on health problems and health care in hospitals and similar institutional environments. The statistical reports and analyses produced will be used for many purposes including quality assurance, health planning and research.

ICD-9-CM contains over 10,000 five-digit diagnostic codes and more than 3,000 four-digit medical procedure codes. HEW said the system is compatible with the existing international classification of diseases, ninth revision, produced by the World Health Organization," and provides a significant improvement' over the classification systems now in use in the United States."

Currently, the two major disease classification systems being used throughout the nation are the ICDA-8 and HICDA-2 systems. According to HEW officials, the use of these competing classification systems has made standardization of statistics difficult to accomplish. HEW officials said the universal adoption of the ICD-9-CM as a simple system

would eliminate these problems and that its use would represent a major technical advance in recording health statistics.

HEW has entered into a contract with the Commission on Professional and Hospital Activities (CPHA) to produce adjunct materials necessary for the implementation of this system.

Drug prices.

A federal draft guide of pharmacy prescription drug prices intended for physicians has been labeled "extremely misleading" by the Pharmaceutical Manufacturers Association (PMA).

"Truly relevant data could be a useful adjunct to existing information sources, but we do not believe that this particular model meets this standard," PMA President C. Joseph Stetler said in a letter to the HEW Department.

The PMA said the price book could cause confusion "as pharmacists undertake to make prescribers and consumers understand why their prescriptions do not cost what this book seems to say they should."

HEW used pharmacy acquisition cost data as a base "even though average retail treatment cost information would be less misleading and is readily available," said Stetler.

PMA compared examples of price ratios from the HEW Guide to Average Retail Price Ratios for Typical Prescriptions which it said "clearly showed that the book's price differences were exaggerated."

Expiration dates on drugs.

The Food and Drug Administration will require that most drugs be labeled to specify the date after which they should not be used.

FDA Commissioner Donald Kennedy said the expiration dating requirement — which will cover all prescription drugs and most non-prescription drugs — should "provide a new protection for consumers, who will have further assurances that the drugs they purchase retain their quality."

Under the old rules, expiration dates were required only for drugs which were liable to deterioration such as antibiotics.

Results of Standard Surgical Treatment of Colon and Rectal Carcinomas — A. B. Peloquin (Hopital Notre-Dame, Montreal, Ontario, Canada) *Can J Surg* 21:39-41 (Jan) 1978.

In a review of 1,550 cases of cancer, 545 were of the rectum and 1,005 of the colon. A survey of patients with rectal cancer treated during successive periods shows that over the years there has been no improvement in survival rates after standard surgical treatment. On the contrary, in the case of colon cancer, there has been a significant improvement in the crude survival rate (from 32.5% to 63.2%). Over the 28-year period studied, there was an increase in the resectability rate (from 71.8% to 90.4%) and a decline in operative mortality (from 12.1% to 2.9%). Moreover, the number of patients over 70 years of age tended to increase. These three factors combined can explain, at least partly, the rise in the crude survival rate. The corrected survival rate excludes these factors since it is based on only the resected cases and excludes postoperative deaths and deaths from intercurrent disease. Nevertheless, there was an evident improvement in this survival rate as well, which rose from 46.2% to 75.4%. These gratifying results can therefore be attributed to an improvement in surgical technique: more extensive resection with high ligation of the pedicle, and thereby the prevention of dissemination of cancer cells.

Trends in Urban Mortality in Relation to Fluoridation Status — E. Rogot et al (Epidemiology Branch, National Heart, Lung and Blood Institute, National Institutes of Health, Bethesda, MD 20014) *Am J Epidemiol* 107:104-112 (Feb) 1978.

Mortality trends from 1950 to 1970 were studied for 473 cities in the United States with populations of 25,000 or more (in 1950) according to fluoridation status of their water supplies. Findings showed no relationship between fluoridation and observed changes in general mortality during the 20-year period. Also, no relationship was found between fluoridation and heart or cancer death rate trends.

Radiation-Related Thyroid Carcinoma — J. M. Cerletty et al (Milwaukee County General Hosp, Milwaukee, WI 53226) *Arch Surg* 35:1072-1076 (Sept) 1978.

Of 1,825 persons with a history of head or neck irradiation, 358 (19.6%) were found to have thyroid abnormalities. One hundred sixty-five (9%) had either single or multiple nodules, 153 (8.4%) had diffuse thyromegaly, and 40 (2.2%) had had thyroid surgery. Surgery was performed on 113 subjects with nodules; carcinoma was found in 34 (30.1%). Clinical examination of the neck was the most valuable method of detecting abnormalities. Detection of nodules was not significantly enhanced by routine use of thyroid imaging studies. Measurements of levels of serum thyroid-stimulating hormone, thyroxine, triiodothyronine resin uptake, and thyroid antibodies were not useful in screening for nodules or carcinoma.

Abdominal Wall Tenderness — H. Thomson (Gloucester Royal Hosp, Gloucester, England) and D. M. A. Francis, *Lancet* 2:1053-1054 (Nov 19) 1977.

One hundred and twenty patients admitted as an emergency with localized abdominal pain were tested for abdominal wall tenderness. Of the 24 patients with a positive test only one had a detectable intraabdominal cause. In the remaining 23 no reason for the pain could be found.

Fat Necrosis of the Breast — J. E. Meyer et al (Pondville Hosp, Walpole, MA 02081) *Arch Surg* 113:801-805 (July) 1978.

Fat necrosis may mimic malignancy on both mammographic and clinical examination. The mammographic appearance is a reflection of the reparative phase of the lesion, with a cystic appearance representing early or incomplete healing. Progression to connective tissue invasion appears as an irregular, dense, spiculated mass. Clinically, these tumors may be firm, fixed, and produce overlying skin or nipple retraction. No matter how strong the clinical suspicion that a breast lesion represents fat necrosis, an excisional biopsy is necessary for confirmation in all cases.

Legionnaires' Disease: Diagnosis and Management — Center for Disease Control (US Department of Health, Education and Welfare, Atlanta, GA 30333) *Ann Intern Med* 88:363-365 (Mar.) 1978.

Legionnaires' disease, an acute bacterial infection commonly manifested as pneumonia, has recently been recognized in outbreaks and sporadic cases. Most documented cases have occurred during the summer and in middle-aged or older persons. Clues to the diagnosis include nonproductive cough, pleuritic chest pain, diarrhea, and confusion. Moderate leukocytosis and nodular consolidation typically are seen on chest roentgenograms. Diagnosis may be made by culture of the fastidious Gram-negative bacillus from lung tissue or pleural fluid, demonstration of the organism in lung tissue by the direct fluorescent antibody technique, or documentation of a significant rise in serum titer by the indirect fluorescent method. Erythromycin is recommended for therapy.

Daily Alcohol Consumption and Fatal Coronary Heart Disease — C. H. Hennekens et al (180 Longwood Ave, Boston, MA 02115) *Am J Epidemiol* 107:196-200 (Mar) 1978.

From 568 married white men who died from coronary heart disease (CHD) and an equal number of matched controls, information was collected on a large number of variables, including daily alcohol consumption. The crude matched pair ratio estimate for any versus no daily drinking was 0.6 (95% confidence limits to 0.4 to 0.7). After controlling for additional confounding variables the risk ratio for any versus no daily alcohol consumption was 0.6 (0.5 to 0.8). This preventive effect was restricted to light drinkers, defined as those who drank < 59.2 ml (2 oz) of alcohol daily. These data provide strong evidence against a causal role of daily alcohol consumption in fatal CHD and are consistent with a small preventive effect of any versus no daily drinking, which is attributable only to light drinkers.

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OF MEDICINE

Before prescribing, please consult complete product information, a summary of which follows:

The effectiveness of Valium (diazepam) in long-term use, that is, more than 6 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discontinue therapy if they intend to or do become pregnant.

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status.

Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals under careful surveillance because of predisposition to habituation/dependence. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), i.e., phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary, not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoaesthesia, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

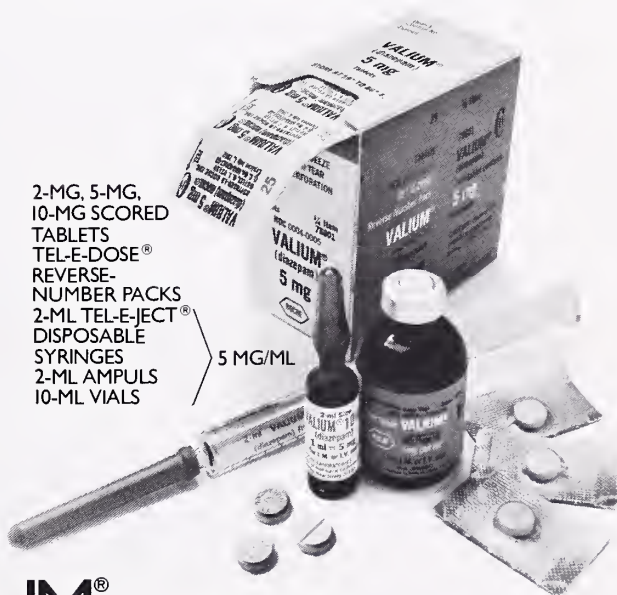
In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

Supplied: Tablets, 2 mg, 5 mg and 10 mg, bottles of 100 and 500; Tel-E-Dose® (unit dose) packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1, Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.



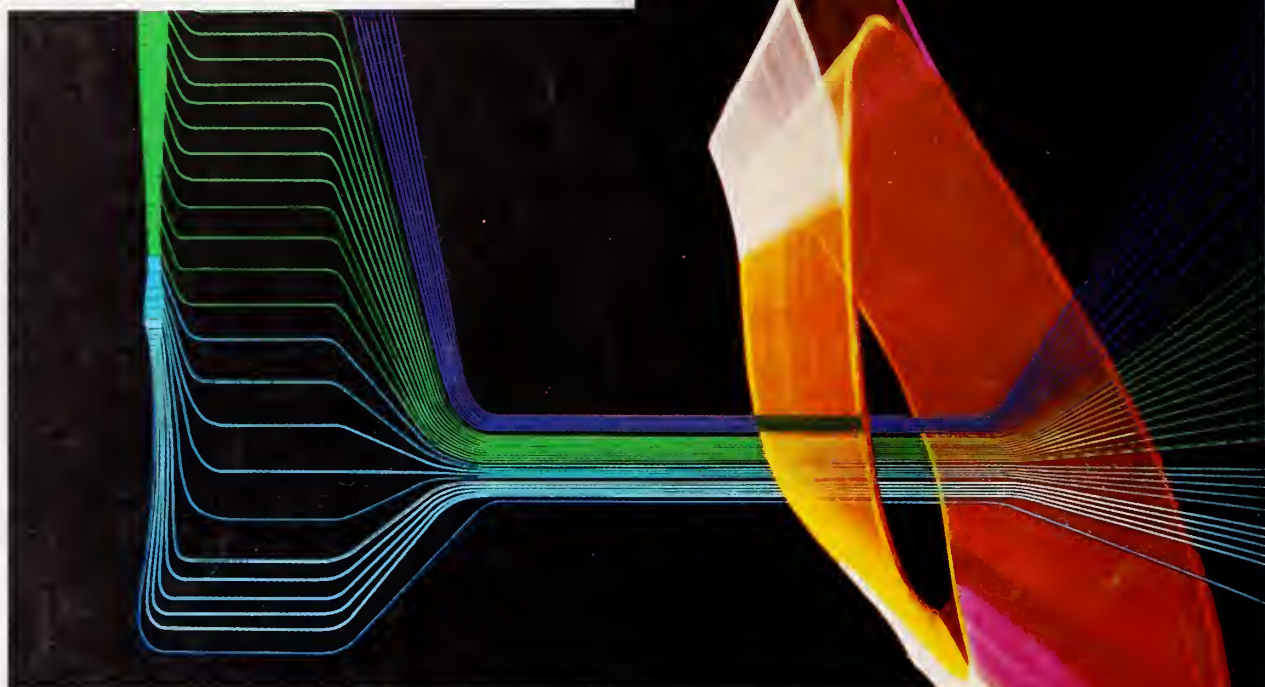
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December, 1978

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Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neurophrenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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Chronic Renal Failure in Children — J.G. Mongeau et al (Hopital Sainte-Justice, Montreal, Quebec, Canada) *Can Med Assoc J* 118:907-913 (Apr 22) 1978.

Seventy-seven children with chronic renal failure were examined between 1970 and 1975, an incidence of 2.5 per million population per year. The entities responsible for chronic renal failure were urinary tract malformation (in 35%), chronic glomerulonephritis (in 22%), congenital renal parenchymal malformation (in 21%), and hereditary nephropathy (in 13%). The evolution of chronic renal failure in children with either vesicoureteral reflux or a posterior urethral valve seemed to be related more to the initial severity of the disease than to the age at the time of diagnosis. Hence any screening program designed to detect kidney disease in schoolchildren would not prevent chronic renal failure, since at that age renal parenchymal damage seems to be irreversible. The manner in which chronic glomerulonephritis evolved depended on whether the nephrotic syndrome was present and on the type of histologic lesion. Children with congenital renal hypoplasia or dysplasia often had seizures due to hypertensive encephalopathy without obvious symptoms or signs of pre-existing renal disease. Among patients with cystinosis underwent successful renal transplantation early in life.

Contraceptive Steroids and Breast Cancer — J. D. Spencer et al (Guy's Hosp, London, England) *Br Med J* 1:1024-1026 (Apr 22) 1978.

The prognosis and pathological findings in 44 patients with breast cancer who had taken contraceptive steroids during the year before diagnosis were compared with those in 44 matched controls. No significant differences between the two groups could be found in the histological features of the tumor or extent of axillary lymph node disease. In patients with involved axillary nodes, the recurrence rate in the controls was significantly higher than in the study group and more of the control patients had died. Oral contraceptives have no untoward effect on the prognosis of breast cancer.

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Anomalies of Motor Development in Hyperactive Boys — M. B. Denckla (Children's Hosp Medical Center, Boston, MA 02115) and R. G. Rudel, *Ann Neurol* 3:231-233 (Mar) 1978.

Forty-eight boys who scored high on rating scales for the hyperactive syndrome but who had no traditional neurological signs of learning disabilities were compared with 50 control boys on coordination tests. Discriminant function scores for speed, rhythm, and overflow correctly classified 89% of the 48 boys as those with hyperactive behavioral histories. Thus, neurological examination of hyperactive boys does reveal developmentally immature coordination.

Combined Chemotherapy and Radiotherapy for the Treatment of Small Cell Carcinoma of the Lung — J. G. W. Burdon et al (Respiratory Lab, Royal Melbourne Hosp, Parkville, Victoria, Australia) *Med J Aust* 1:353-355 (Apr 8) 1978.

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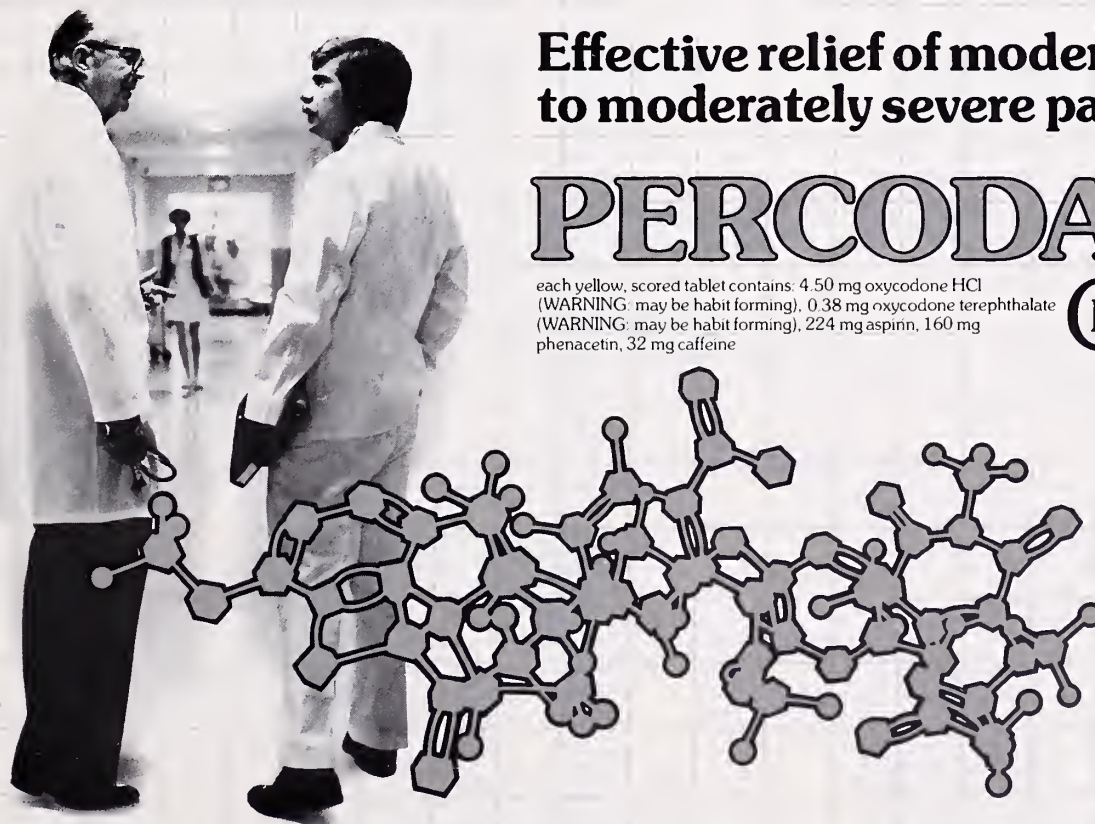
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Management of the Appendiceal Mass — B.
Foran et al (T. V. Berne, Los Angeles
County - Univ of Southern California
Medical Center, Los Angeles, CA 90033)
Arch Surg 113:1144-1145 (Oct) 1978.

The records of 43 patients with clinically diagnosed appendiceal abscess were reviewed to compare operative vs non-operative therapy. Thirteen patients were operated on shortly after admission. Eleven of these had appendectomy or drainage of an abscess; two patients had right hemicolectomy. There were no serious complications, and median hospitalization was 7.2 days. Thirty patients were initially treated non-operatively. Twenty-six of these did well and were discharged a median of 11 days after admission. Four patients required operations for failure to respond; one died of a pulmonary embolism. Four patients returned with recurrent appendicitis and underwent appendectomy. Three patients were later found to have other disease processes. Good results can be obtained with either form of therapy. Patients not operated on should be examined to exclude lesions masquerading as appendiceal abscesses.

Inflammatory Carcinoma of the Breast — F.
V. Lucas and C. Perez-Mesa (Ellis Fischel
State Cancer Hosp, Columbia, MO 65201)
Cancer 41:1595-1605 (Apr) 1978.

Fifty-eight patients with clinical inflammatory breast carcinoma and 15 patients with occult inflammatory cancer (dermal lymphatic carcinomatosis without clinical inflammation) were reviewed to determine whether diagnosis is pathologic or clinical. Lesions of clinically apparent and occult inflammatory carcinoma showed similar gross and microscopic growth patterns, histologic types, axillary involvement, and early widespread metastases. Regardless of pathologic evidence of dermal lymphatic tumor, patients with clinical inflammation had rapid deterioration. Patients with only a pathologic diagnosis were slightly less fulminant in progression. Either clinical or pathologic criteria justify use of the term inflammatory breast carcinoma to indicate short-term prognosis despite available treatment.

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is

affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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The Internal Mammary Bypass Graft — J. W. Jones et al (Dept of Surgery, Tulane Medical Center, New Orleans, LA 70112) *J Thorac Cardiovasc Surg* 75:625-631 (Apr) 1978.

In 1,004 consecutive patients who had direct coronary artery bypass, computer methods of data processing were used to compare the clinical results between patients who had saphenous vein (SV) grafts and those who had internal mammary artery (IMA) grafts. The factors compared were rates of long-term mortality and nonfatal myocardial infarction, relief or persistence of angina, and the percentage of patients who acquired congestive heart failure. A simple comparison showed that patients with IMA grafts did better in all four categories; however, in a subsequent analysis in which maldistributed factors were removed, the rates of anginal relief and congestive heart failure were not significantly improved. The major benefit appears to be an increase in longevity among patients who had IMA bypasses.

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Changes in Renal Function in Essential Hypertension — F. C. Reubi et al (Medizinische Universitäts-Poliklinik, Berne, Switzerland) Am J Med 64:556-563 (Apr) 1978.

Renal hemodynamics, plasma renin activity (PRA), plasma aldosterone, and water and sodium excretion were studied in 171 patients with essential hypertension and 61 normotensive subjects. The para-amino hippurate clearance (C_{PAH}) was usually normal or moderately reduced in those with benign hypertension and markedly depressed in those with malignant hypertension. The PAH extraction ratio was normal or slightly reduced in the patients with benign hypertension and moderately impaired in those with low C_{PAH} indicating that a disproportionate decrease in cortical flow occurred only in the latter. The C_{PAH} did not correlate inversely with the mean blood pressure in the patients with benign hypotension. Re-examination of untreated patients after an average of 28½ months revealed a decrease in renal plasma flow but no further increase in blood pressure. In uncomplicated hypertension the increase in blood pressure may not be caused by renal circulatory disturbances. PRA was unrelated to renal hemodynamics in benign hypertension. In malignant hypertension, it was inversely correlated with the renal plasma flow. Under mild loading with isotonic saline solution, the fractional water excretion correlated with the blood pressure. Sodium excretion was neither related to the blood pressure nor to the estimated peritubular oncotic pressure, but correlated inversely with plasma aldosterone.

Infectious Mononucleosis in the Older Patient — J. W. Carter et al (Mayo Clinic, Rochester, MN 55901) Mayo Clin Proc 53:146-150 (Mar) 1978.

Six cases of infectious mononucleosis in patients older than 60 years old were reviewed. The geriatric patient often has nonspecific constitutional symptoms, without exudative pharyngitis. The disease may present as fever of obscure origin or mimic chronic lymphocytic leukemia in this age group. Diagnosis is established through characteristic findings in hematologic and serologic studies.

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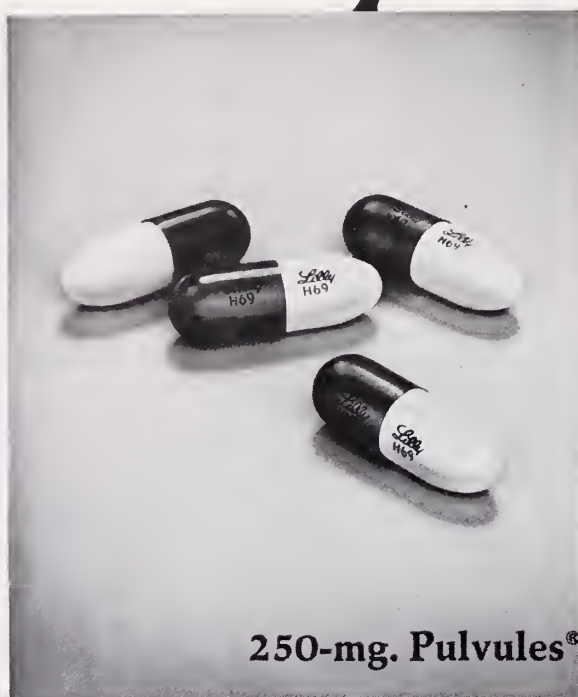
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SECOND OPINIONS ABOUT
SECOND OPINIONS

1. When the nurses say they are missing a sponge, the sponge count is repeated. If the second count indicates that they are *not* missing a sponge, the second count is considered to be correct. In fact, it may be wrong, but it is pleasing, and it is accepted. The second opinion is like the sponge count. If the first surgeon says operate, and the second one says no, it will usually be assumed that the second opinion is right, but there is no justification for this.

2. It is implied that the first doctor, the one who says operate, is wrong.

3. Suppose the first doctor says don't operate, and the second says do.

4. What is elective surgery, where second opinions are to be sought?

5. Can the first doctor defend himself?

6. *Must* the patient get a second opinion?

7. Who will give the second opinion: a member of a panel? Who will appoint the panel? Who are peers?

8. If the second doctor says don't operate, do you not operate? Or do you get a third opinion? And a fourth?

9. Suppose there is only one doctor in town. Or two, and they are partners?

10. *Must* the patient take the advice of the second doctor?

11. The second opinion philosophy implies unwillingness to seek consultation.

12. Consider the expense to be borne by the patient, and ultimately by everybody.

13. And think of the anxiety brought about when the patient runs from one doctor to another, and cannot make up his mind.

14. We have always had consultation, and this is all second opinion is, but will the second opinion revolution do good or harm? It is worth thinking about these things.

15. Choose your doctor, and when you do, have you not singled out one whose skill and

integrity you admire? You must finally *accept and share* responsibility. And there is always consultation.

—F.C.

WE'RE INDISPENSABLE TOO

I am tired of strikes where buildings burn down, garbage is not collected, airplanes do not fly, much-needed food is not produced or is not transported, and mail is not delivered; I am not critical of labor; I *am* labor. But always there is the message: see how indispensable we are, you can't get along without us.

Well, we have division of labor; I do not make my own shoes, the housepainter does not plant potatoes, the fireman does not sew his own clothes, and the poet does not print his own poems. We are all specialists. But when pilots and firemen strike often, *we* do not, a smaller-than-average number of doctors remain unstruck and carry on.

Electric companies tell us how indispensable they are, letter carriers show us how necessary they are, garbage removers impress us with their importance, by letting letters and refuse pile up, by halting trains and planes, and by power failure.

You can't get along without us, they say. You can't get along without the garbage hauler, or without the mail deliverer or without the fireman or the farmer or all the others we are told we can't get along without.

Well, we're indispensable, too. I'd move to an island today but for one thing. I'd need a doctor some day. And you sure can't get along without doctors.

—F.C.

ON THANKSGIVING

I have just looked at a small newsmagazine published by an organization to which I belong, and on the second page somebody I never heard of thanks eight people I never heard of. Authors sometimes thank people at the end of a manuscript, which has always

seemed odd and even wrong to me; and of course, people thank people at the beginning of books, and the people who are thanked are individuals of no importance to the reader.

I don't think that is the way to thank people. Dedicating a book to your wife is one thing, and it is strange, too, for what does dedicating mean? But if you want to thank people, just go over to them and say Thank you. Or send them a thank-you letter.

But not at the end of a scientific manuscript.

Thank you.

—F.C.

MY STARS

I am an early, six o'clock early, morning walker. And I do not believe in freedom of the will; determination is what I stick to. I look up at Sirius and I know it for what it is, a blazing atomic furnace; and at Capella and at Regulus, and I wonder: what are they for?

They are so far away; we are warmed by our own star, and ours is a triumph of physics, but there is Polaris, and there are Antares and Vega and others I cannot call by name. But they are there and I know they are far away, they are too far from me to do me any good. And I know what they are doing; they are changing matter into energy at an unthinkable rate.

I think we are alone.

But what are the stars for? What are they doing there?

—F.C.

NEW DRUGS

There is a new drug that seems to be useful in preventing pregnancy or in relieving pain or inducing sleep or lowering blood pressure. It will take 20 years to know if it is free from side effects and if it is safe. If it is not released for use, many people will be deprived of its benefits, while it may be beneficial and safe. Animal tests tell us that it is a good agent, and critics say that animal tests are not human tests. The drug can be given to patients who are willing to take it, knowing that it is untested, and assuming responsibility fully, so that neither the physician nor the manufacturer will be liable.

Insulin and cardiac valve replacement were tried in laboratory animals, and then, *cautiously*, I think, in people. But between animals and people, between not knowing, and knowing, side effects, there is that *cautiously*, or what lawyers call gray period. And the problem confronting the investigator is, how shall it be crossed?

There was thalidomide, which fortunately and properly, was not approved. And we read too often of drugs that may be had in other countries, and why not here? There is a good reason for saying, not here, not yet. Remember thalidomide. And there is laetrile, and before that krebiozen was available. Are large doses of ascorbic acid good for you, and are they free of harmful side effects?

Testing and releasing and approving of drugs can be difficult; look at saccharin and cyclamate, and the changing of minds. Criticizing is easy; deciding is hard. Testing on human beings was once done without too much hesitation; this has changed. Be patient; suppose you had to do the experiment.

—F.C.

Internists and Internal Medicine in Nebraska: 1976

THE purpose of this report is to review the number, practice sites and selected characteristics of internists in practice in Nebraska in 1976. Furthermore, characteristics of the residency program at the University of Nebraska College of Medicine are related to present and projected future needs for internists in Nebraska.

1. NUMBER OF INTERNISTS:

In 1976 there were 126 internists in private practice in Nebraska (Table I). This number is derived from Nebraska Health Manpower Report, 1976, from the Nebraska State Department of Health. It is a self designation of the nature of practice by each physician. Approximately half are certified by the American Board of Internal Medicine. Seventy (70) internists are geographic full time faculty members at Creighton and the University of Nebraska. Residents in training numbered 106. Although this report places primary emphasis on internists in private practice it should be noted that the residents and faculty (a total of 176) provide medical care for a large number of patients.

TABLE 1

INTERNISTS IN NEBRASKA: 1976^a

TOTAL	302
RESIDENTS	<u>106</u>
PRACTICE	196
MEDICAL SCHOOL FACULTY	
NEBRASKA (40)	
CREIGHTON (30)	<u>70</u>
PRIVATE PRACTICE	<126 ^b

a. Nebraska Health Manpower Reports, Nebraska State Department of Health, 1976. Data Obtained from questionnaire to each physician licensed in Nebraska. Of 4,552 with a Nebraska License, 2,199 are in Nebraska of whom 2,096 are in active practice. These gross numbers include residents in training programs; 429 residents (20%) are included in the 2,096 active physicians.

b. Not adjusted for a small number (less than 10) institutional internists (Lincoln and Grand Island, VA, others).

JOSEPH C. SHIPP, M.D.

Professor and Chairman

Department of Internal Medicine

University of Nebraska College of Medicine

Omaha, Nebraska 68105

2. EDUCATION OF INTERNISTS:

(Table 2) Approximately 75% graduated from either the University of Nebraska (55%) or Creighton (18%). Residency training for over half (62%) was obtained at institutions in other states. This trend is changing with the expansion of residency education programs at the University of Nebraska College of Medicine since 1970. Twenty-four practicing internists completed residency training at UNMC since 1970 (Table 4).

3. AGE OF INTERNISTS:

(Table 3) In general the average age of internists is under 50 reflecting the recent additions of an increased number following completion of residency training. Sites with an average age of approximately 60 (such as Hastings and Beatrice) suggest the opportunity for more internists.

4. GEOGRAPHICAL LOCATION:

The population, the number of internists, the number of hospitals and the total number of physicians are shown in Table 4. The number of internists in Omaha and Lincoln is not surprising. Of these fewer than 20% practice predominantly subspecialty medicine. What is noteworthy is the number (39 or 39%) practicing in the other major population centers. This is a growing number. Among the practicing internists, with residency training at UNMC since 1970, approximately $\frac{1}{3}$ are in areas other than Omaha and Lincoln (Table 4, Column D).

5. RELATIONSHIPS OF INTERNISTS TO OTHER PHYSICIANS: (Table 5)

Nationally, approximately 20% of all physicians are internists; among the federally

TABLE 2

INTERNISTS IN NEBRASKA: 1976

<u>TOTAL</u>	<u>MEDICAL SCHOOL</u>			<u>RESIDENCY</u>			<u>AGE</u>
	<u>No/%</u>			<u>No/%</u>			<u>(median)</u>
	<u>NEBRASKA</u>	<u>CREIGHTON</u>	<u>OTHER</u>	<u>NEBRASKA</u>	<u>CREIGHTON</u>	<u>OTHER</u>	
126*	69 (55%)	23 (18%)	34 (27%)	32 (25%)	16 (13%)	78 (62%)	46

*Excludes house officers and faculty members at Nebraska and Creighton.

designated primary care specialties (internal medicine, family practice, and pediatrics) 66% were internists. In Nebraska, internists account for approximately 9% of all physicians and for 22% of primary care specialties.

6. FUTURE OPPORTUNITIES FOR INTERNISTS:

Estimates of the number of internists needed for a given population in this country are difficult because of the nature of medical practice in this country. For primary care, Schonfeld, et al (N. Eng. J. Med. 286: 571-576, 1972) has suggested the need of one physician per 750 adults. This number was indicated by a detailed analysis of the types of problems with which patients present, the time required to effectively treat these patients with these problems, and estimated physician work week. This approach is logical and rational but it assumes a system in which all people have equal access to primary care. This is not what exists today in the U.S. or in Nebraska.

A somewhat better estimate of the need for internists is available from the large prepaid groups such as the Kaiser - Permanente System, and others. (Mason, H. R., JAMA 219: 1621-26, 1972) Even with groups who provide near total care for a population group the number of internists is influenced by the mix of primary care physicians, and by the extent of inclusion of physician extenders (physician assistants and nurse practitioners).

TABLE 3

AGE OF INTERNISTS IN NEBRASKA

<u>LOCATION</u>	<u>AVERAGE AGE</u>
Beatrice	62
Fremont	45
Grand Island	41
Hastings	58
Kearney	42
Lincoln	50
Norfolk	46
North Platte	29
Omaha	48
Scottsbluff	34

However, with the reservations noted, it is likely that a reasonable and conservative ratio of internists/population is in the range of 1:3000 to 1:5000. The ultimate test is whether the internist — in relationship to all other factors — meets the needs and desires of the people at a price they are willing to pay.

TABLE 4
Internists in Nebraska 1976: Geographical Location^a

County	A Population	B City (Major)	C Number of Internists ^b	D UNMC Residency Since 1970	E Estimates of Need ^c		F Estimated Additions Needed ^d		G Hospitals	H Total Physicians ^e
					High	Low	High	Low		
State	(1,552,858)		126	24	517	310	321	184	105	1,348
Douglas	(414,988)	Omaha	56	14	138	83	88	33	12	470
Lancaster	(182,946)	Lincoln	31	3	61	37	30	7	6	257
Buffalo	(32,811)	Kearney	6	1	11	7	4	0	1	40
Hall	(44,914)	Grand Island	5	3	15	9	10	4	3	40
Adams	(30,210)	Hastings	5	0	10	6	5	1	2	43
Scottsbluff	(36,994)	Scottsbluff	5	0	12	8	8	4	2	49
Dodge	(35,459)	Fremont	4	1	12	7	8	3	1	21
Gage	(23,617)	Beatrice	3	0	8	5	5	2	2	23
Madison	(28,767)	Norfolk	3	0	9	6	6	3	3	32
Lincoln	(34,482)	North Platte	2	2	11	7	9	5	1	29
Platte	(27,833)	Columbus	2	0	9	6	7	4	1	16
Sarpy	(79,912)	Bellevue	2	0	28	16	26	14	1	33
Red Willow	(12,569)	McCook	1	0	4	3	3	2	1	10
Morrill	(6,055)	Bridgeport	1	0	2	1	1	0	1	3
Totals	(991,557)		126	24	330	201	210	82	37	1,066

FOOTNOTES: TABLE 4

a. Nebraska Health Manpower Reports, Nebraska State Department of Health, 1976.

b. Net number in private practice which does not include residents in training or those on the full time faculty of the two medical schools. Full time faculty members in internal medicine in 1976 were 40 at Nebraska and 30 at Creighton.

c. This projection is based on 1 internist for each 3,000 (high) or 5,000 (low) people. See page 4 for justification.

d. This net estimate is the difference between columns 5 and 3. No attempt has been made to estimate the effect of deaths, retirement, change in practice or geographic moves.

e. Total physicians in practice does not include full time faculty members of the two medical schools in Douglas County. Full time clinical faculty in 1976 was 184 at Nebraska and 135 at Creighton.

Let us assume one internist per 5000 people for Nebraska. (Table 4, Column E). This suggests the need for a total of 310. (versus 126 in 1976). To reach and maintain this number would require the addition of 184. This conservative estimate does not account for the number leaving practice due to retirement, death or for other reasons. It is not unreasonable to suggest one internist for each 3000 people in Nebraska; this would lead to a projected need of over 500 and needed additions in excess of 300 (Table 4, Columns E and F).

7. RURAL HEALTH:

Rural health is an important issue in Nebraska, as elsewhere. Internists are an important part of the solution to this

problem. Our geography of towns along the Platte River is a positive feature. Internists function best in groups and with supporting laboratory, x-ray and hospital services. This is exactly what exists today in "medical centers" throughout Nebraska (see map). The first step in medical care is access; this means the individual has a problem which he thinks can be helped by a physician. Let's assume "access" can be assured by effective education of the people. Then, the telephone, automobile and good roads would have over 80% of the people of Nebraska within minutes of physicians, including internists, in "medical centers." This could be expanded by various other approaches (such as physician assistants who work with a group of primary care physicians and provide initial contact medical care for people in less populated areas) if the people, and physicians, desire.

TABLE 5

PHYSICIANS - 1976*

	<u>TOTAL</u>	<u>INTERNAL MEDICINE</u>	<u>FAMILY PRACTICE</u>	<u>PEDIATRICS</u>	<u>OTHER</u>
USA*	357,762	69,901 (19%)	11,854 (3%)	23,516 (7%)	252,491 (71%)
Nebraska**	1,348	126 (9%)	239 (18%)	51 (4%)	932 (69%)

*Source: Fischer-Stevens, Inc. U.S. Distribution of Physicians, April-May, 1976.

**See Footnote of Table 4.

% = % of total physicians

8. RELATIONSHIP OF RESIDENCY PROGRAM AT UNMC TO ESTIMATED NEEDS OF THE STATE

RESIDENCY YEAR	1976	OPTIMAL
R1	17	20
R2	17	20
R3	13	20
R4, 5	11	15
TOTAL	58	75

The key part of this sequence is the number of R3. Another, is the balance between those who enter practice after three years of internal medicine and those desiring additional training. We can influence this balance but we cannot dictate career choices. Let us assume that five of the 20 R3 choose subspecialty training, that fifteen enter practice and ten remain in Nebraska. Let us assume that eight of those in R4, R5 years enter practice, half in Nebraska. This means about fourteen internists entering practice each year in the state. This seems to be both reasonable and conservative in relationship to the developments in internal medicine which I have observed in Nebraska since 1970. This remains true even when other major factors (Creighton Residency Program; net migration from other states, especially Colorado to western Nebraska; family practice) which will affect the practice of medicine in Nebraska are considered.

9. RESIDENTS IN INTERNAL MEDICINE PROGRAM AT UNMC SINCE 1970:

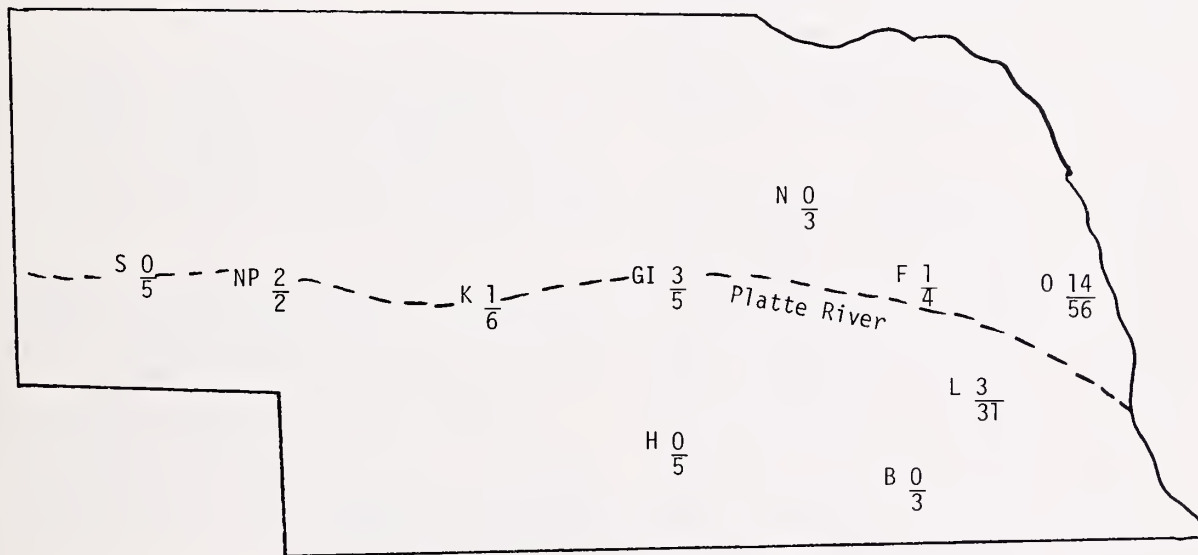
In the period 1970-76 there have been 150 residents in training in internal medicine. Of the 92 who have completed residency training the following are noteworthy:

- a. Sixty-seven residents (73%) who had all or part of their training are in practice.
- b. Of those in practice, 57 are practicing internal medicine. Subspecialty medicine is a major component of practice for ten. Seven entered practice after one or two years of residency. Three are practicing in other medical specialties.
- c. Fourteen are geographic full time university faculty members; eleven are faculty members of this department. This is an expected and desirable sequence during a period of intense faculty development.
- d. Fifty-one percent of those who completed the residency program in internal medicine at UNMC have remained in Nebraska.
- e. Over 90% of those who completed the full three year basic residency in internal medicine have been certified by the American Board of Internal Medicine.
- f. The major emphasis of the program in internal medicine at UNMC has been and will continue to be training in general internal medicine.

Since the preparation of this report 30 additional residents have completed their graduate training in the Department of Internal Medicine at the Nebraska Medical Center. Thirty are in practice with twenty being in practice in Nebraska and the region. Specifically (see Geographic Distribution of

Internists) this increases the number of Internists trained at U.N.M.C. and Grand Island from 3 to 4, Fremont from 1 to 3, Hastings from 0 to 2, Lincoln from 3 to 4 and Omaha 14 to 22. Additional Internists have entered practice in the region, including two in South Dakota and three in Iowa.

THE GEOGRAPHIC DISTRIBUTION OF INTERNISTS IS NOTEWORTHY:



CITIES: O = Omaha
L = Lincoln
GI = Grand Island
K = Kearney
NP = North Platte
S = Scottsbluff
H = Hastings
N = Norfolk
B = Beatrice
F = Fremont

NUMBERS: Top = Residency at UNMC since 1970
Bottom = Total Internists

Update on the Sudden Infant Death Syndrome in Nebraska

RECENT research has revealed differences anatomically, histologically, chemically, and physiologically in victims of the Sudden Infant Death Syndrome when compared to infants who do not succumb to the disease. A number of investigators have supported the possibility (and probability) that the etiology may not be due to a single cause. A more descriptive diagnosis — Sudden Unexpected and Unexplained Infant Death — has been suggested.

Significant pathological findings have supported the possibility that affected infants have been subjected to chronic hypoxemia. This has manifested itself by an increase in the main pulmonary arterial medial muscle mass due to the combined effects of hyperplasia and hypertrophy. Additional evidence of chronic hypoxemia noted has been more retention of periadrenal brown fat during the first year of life, undue retention of hepatic extramedullary hematopoiesis, more astroglial fibers of the brain stem, and lower hepatic phosphoenolpyruvate carborykinase activity.

The following clinical findings were noted in a significant number of victims of Sudden Unexpected and Unexplained Infant Death when compared to normal controls or siblings. As newborns, they had low (or lower) Apgar scores, many required resuscitation, experienced a higher rate of the respiratory distress syndrome, and were considered feeding problems. Neurological findings were manifested by jitteriness or tremulousness, abnormal Moro reflex, generalized muscular hypotonia, abnormal reflexes and spontaneous hypothermia or hyperthermia. Behavioral differences noted consisted of a less active infant, less intense responses to a variety of stimuli, more often breathless and easily exhausted during feeding and cries of a different pitch. Physical findings such as crown-to-heel length, head circumference, and weight gain were noted to be different.

Because of the differences between groups

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and individual infants who die unexpectedly and unexplainably and normal controls it now seems apparent that babies who die of the Sudden Infant Death Syndrome are not normal at the time of death and probably are never entirely normal.

At the present time there are no definite predictive or diagnostic criterion for those infants who will succumb to Sudden Unexpected and Unexplained Infant Death.

An autopsy is the only assured method of establishing the diagnosis. The paucity of findings or identifying the causes of Sudden Unexpected **Explained** Infant Death confirms the diagnosis.

Considerable variation in the incidence of SIDS has been reported. In 1974 the rate of occurrence was 0.06 per 1000 live births in Sweden and 0.42 in the Netherlands. In 1970 the rate of occurrence in Ontario, Canada was 3.0 per 1000 live births. The incidence in the state of Nebraska for the years 1973 through 1977 is noted in table 1. Since 1974 several reports have noted an apparent decrease in both the number and rate per 1000 live births.

OBSERVATIONS IN NEBRASKA

Since 1973 the Maternal and Child Health Division of the Nebraska State Health Department has reviewed the death certificates of infants dying between the ages of one week and one year. Sudden Infant Death Syndrome was noted as the cause of death on one hundred fifty-six (82%) of the infants in this report. Correspondence with the attending physician or coroner was used to ascertain the additional number of infants who died of SIDS (table 1).

TABLE 1
Number of SIDS Cases Reported and Ascertained,
Rates Per 1000 Live Births for 1973-1977, Nebraska.

YEAR	1973	1974	1975	1976	1977	TOTAL
Total Number Reported And Ascertained	34	40	31	54	31	190
Reported Minimal or Questionable History or Findings	3	8	1	14	3	29
Probable SIDS	31	32	30	40	28	161
Birth Rate	22,771	23,695	23,658	23,767	25,151*	119,042
Rate Per 1000 Live Births	1.36	1.35	1.27	1.68	1.11	1.35

*Provisional

TABLE 2
Number of SIDS Cases Per Year and Percent
Autopsied, 1973-1977, Nebraska.

YEAR	1973	1974	1975	1976	1977
Number of SIDS Cases	34	40	31	54	31
Percent Autopsied	76%	69%	78%	74%	67%

Twenty-nine of the infants either had "minimal or questionable" factors in their history or in a finding at the time of autopsy. The number (161) in the "Probable SIDS" row had the expected history and the typical autopsy findings. The total number (190) reported and ascertained is used in analyzing the following factors.

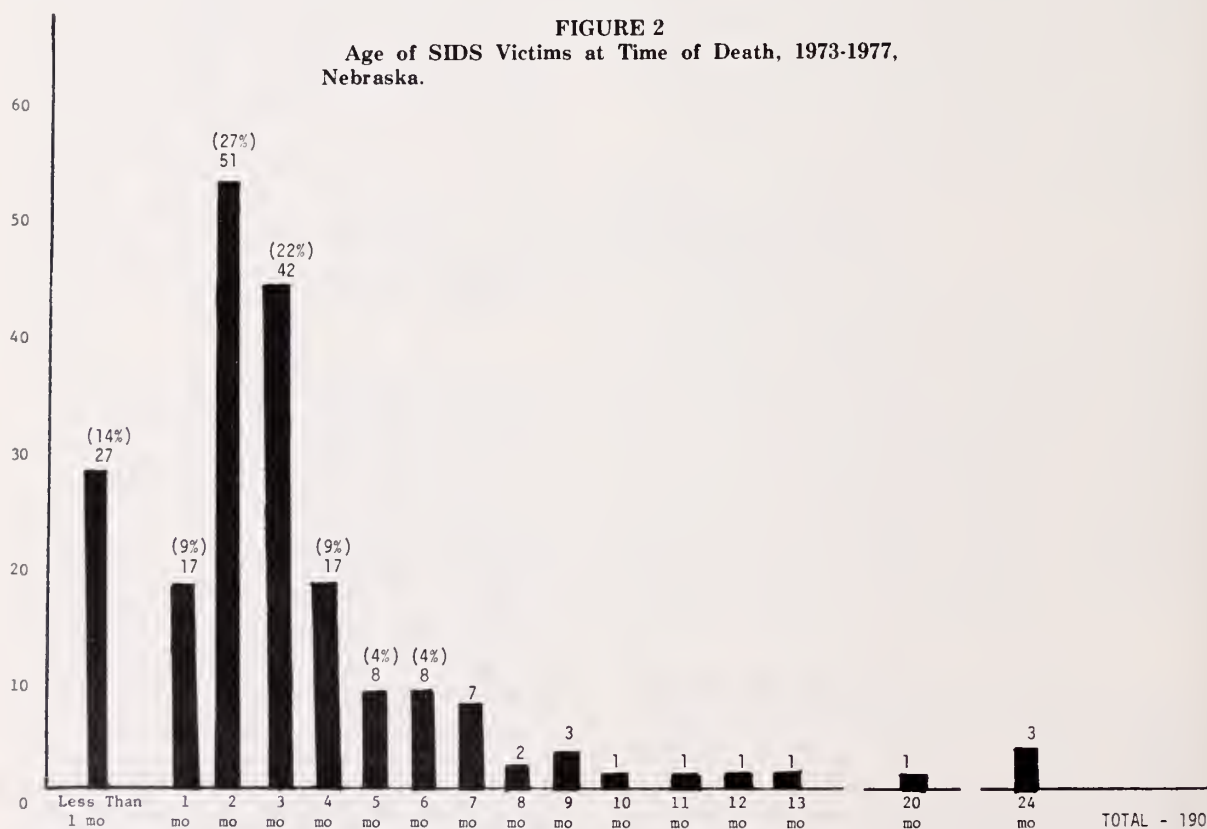
FACTORS RELATED TO THE INFANT

LOCATION (COUNTY) OF DEATH. The numbers represent the number of SIDS deaths occurring in each county during the five year period. As expected, because of population distribution, a concentration of deaths is noted in the eastern half of the state. Fifty per cent (50%) of the deaths occurred in the Omaha and Lincoln areas.

[illegible]

TOTAL - 190

FIGURE 2
Age of SIDS Victims at Time of Death, 1973-1977,
Nebraska.



AGE OF INFANT AT DEATH. The respective numbers and percentages for each age are noted in figure 2. The peak incidence of deaths occurred at both two (27%) and three (22%) months of age. Twenty-three

percent (23%) of the victims were noted to be under two months. Eighty-two percent (82%) of the infants were four months or less at the time of their death. Five infants were older than one year; 1 - 13 months; 1 - 20 months; 3 - 24 months.

GESTATIONAL AGE CALCULATED FROM DATE OF LAST MENSES. Twenty-five (13%) had gestational ages thirty-six weeks or less. An additional forty-eight (25%) had gestational ages between thirty-seven and thirty-nine weeks. The gestational age was unknown in fourteen (7%) of the infants.

BIRTH WEIGHT OF THE INFANT. Thirty-one (16%) of the infants weighed less than five and one-half pounds at birth. Thirty-eight (20%) weighed between five and one-half pounds and six pounds seven ounces. One hundred-fourteen (60%) had birth weights above six pounds eight ounces. The weights were unknown in seven (4%) of the infants.

SEX OF THE INFANT. The distribution is presented in table 5. The higher incidence

of males has been reported repeatedly in other studies.

RACE OF THE INFANT. During the five year study one hundred fifty-nine (83%) of the infants were noted to be white and twenty-four (13%) were black. Seven infants (4%) were of the following minorities: Indian - 4; Mexican-American - 2; and Oriental - 1.

FACTORS RELATED TO THE MOTHER

MATERNAL AGE. Fifty-five (29%) of the mothers of SIDS victims were less than twenty years. Seventy-three (38%) of the mothers were twenty to twenty-four years old. Fifty-five (29%) of the mothers were twenty-five or older. The ages of seven mothers (4%) was unknown.

LEGITIMACY OF BIRTH. One hundred forty-seven (77%) of the infants were of

TABLE 3
Gestational Ages of SIDS Cases, 1973-1977, Nebraska.

Gesta- tional Age	36 WEEKS OR LESS	37 - 39 WEEKS	40 - 42 WEEKS	UNKNOWN
Number and Percent	25 (13%)	48 (25%)	103 (54%)	14 (7%)

TABLE 4
Birth Weights of SIDS Cases, 1973-1977, Nebraska.

BIRTH WEIGHT	2# 7oz. - 3# 7oz.	3# 8oz. - 5# 7oz.	5# 8oz. - 6# 7oz.	6# 8oz. - AND ABOVE	UNKNOWN
NUMBER AND PERCENTAGE	7 (4%)	24 (12%)	38 (20%)	114 (60%)	7 (4%)

TABLE 5
Sex Distribution of SIDS Cases, 1973-1977, Nebraska.

YEAR	1973	1974	1975	1976	1977	TOTAL
MALE	23 (68%)	27 (68%)	19 (61%)	34 (63%)	20 (65%)	123 (65%)
FEMALE	11 (32%)	13 (32%)	12 (39%)	20 (37%)	11 (35%)	67 (35%)

TABLE 6
Age of Mothers of SIDS Victims, 1973-1977, Nebraska.

AGE YEARS	14 - 19	20 - 24	25 - 29	30 - 34	UNKNOWN
NUMBER	55	73	40	15	7
PERCENT	29%	38%	21%	8%	4%

legitimate birth. Thirty-seven (20%) were illegitimate infants at time of birth. The status of six infants (3%) was unknown.

EDUCATION OF MOTHER. Sixty-four (34%) had eleven or less years of education. Ninety-two (48%) had completed high school. Twenty-six (14%) had completed one or more years of college. The educational status of eight mothers (4%) was unknown.

NUMBER OF SURVIVING CHILDREN. In sixty-two (33%) of the families the SIDS victim was an only child. The number of surviving siblings varied from one living child (37% of the families) to seven. The number of siblings was unknown in eight families.

PRENATAL CARE OF MOTHER. One hundred eleven (58%) of the mothers began their prenatal care during the first trimester. Fifty-five (29%) started prenatal care during the second trimester, and seven (4%) during the third trimester. Five mothers (3%) had

no prenatal care. The prenatal care status was unknown in twelve mothers.

ENVIRONMENTAL FACTORS

MONTH OF DEATH. The number of SIDS deaths per month for the five year period is noted in figure 3. One hundred twenty-five (66%) of the deaths occurred from October through March. Deaths were noted in each month.

TIME OF DEATH. In most series the time of death is calculated at a midpoint between the moment the infant was last seen alive and the moment he was discovered dead. It is assumed that half of the deaths will have occurred prior and half after the midpoint. The times presented in figure 4 are those noted on the death certificates, which represents the time the SIDS victim was discovered dead. One hundred three (54%) of the infants were discovered to be dead between the hours of 5AM and 11AM;

FIGURE 3
SIDS Deaths Per Month, 1973-1977, Nebraska

TOTAL — 190

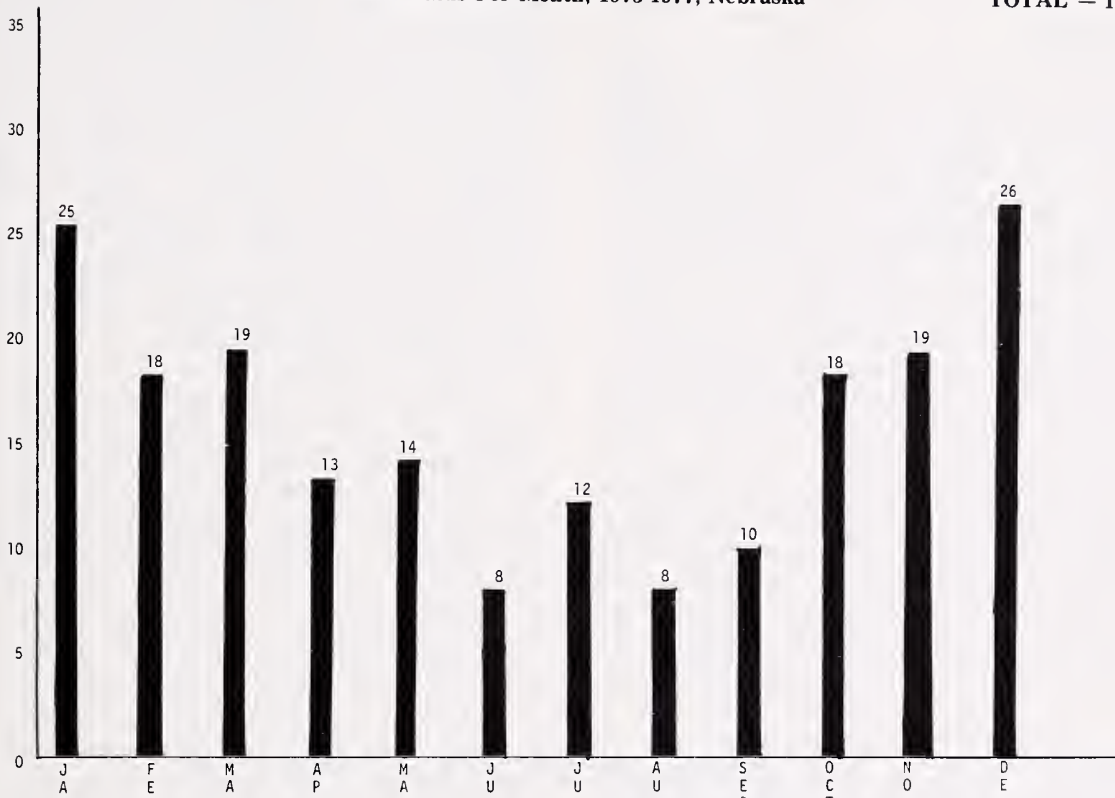
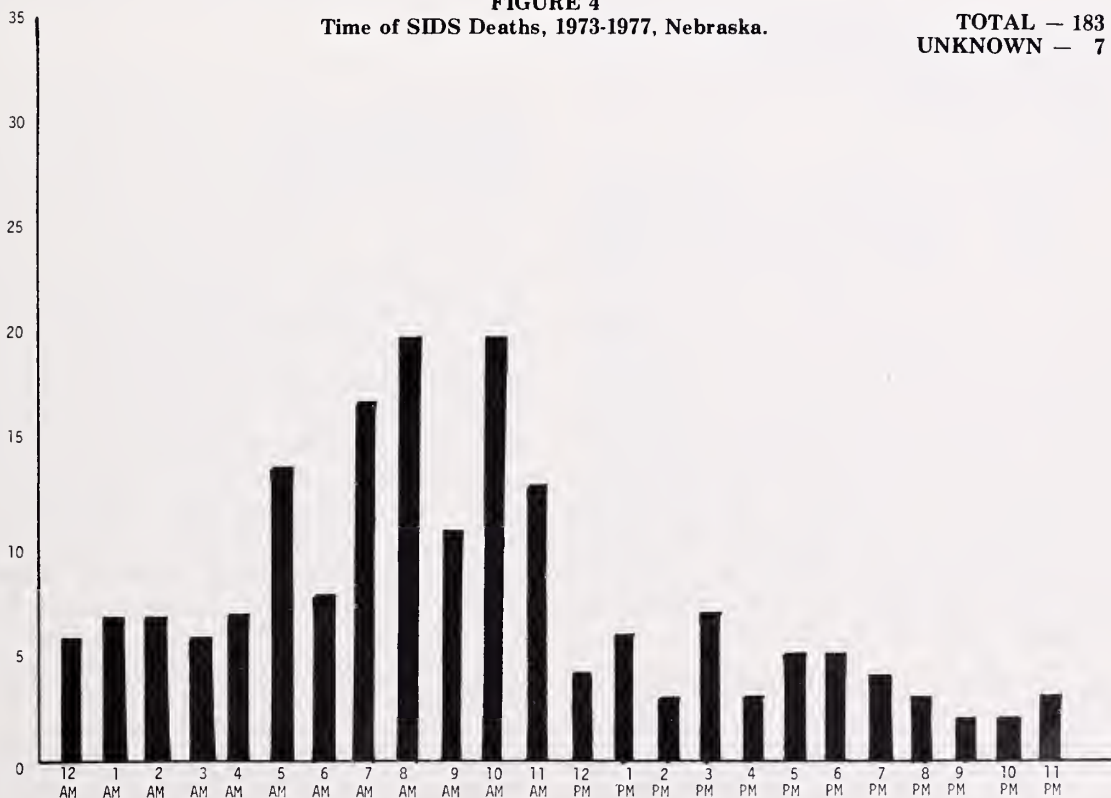


FIGURE 4
Time of SIDS Deaths, 1973-1977, Nebraska.

TOTAL — 183
UNKNOWN — 7



thirty-three (17%) between 12AM and 4AM. No time of death was noted for seven (4% of the infants.

Interest in the Sudden Infant Death Syndrome has been fostered by two national groups — The Sudden Infant Death Foundation and the Guild for Infant Survival. In addition to sponsoring and obtaining national legislation and grants, they have assisted in the formation of state and local chapters consisting of both professional and parent membership. Local chapters have been instrumental in disseminating knowledge of the disease entity, and establishing counseling systems for the parents.

The Nebraska Unicameral passed Legislative Bill 605 which contained the following: 1) that in the case of sudden and unexpected death of a child between the ages of one week and three years an autopsy is to be performed at county expense (unless the

parent or guardian signs a written waiver to right of autopsy); 2) the parent or guardian is notified of the results of the autopsy by their physician, community health official, or county coroner within forty-eight hours; 3) the term Sudden Infant Death Syndrome shall be entered on the death certificate as the principle cause of death; 4) the county attorney or coroner shall within two days of the issuance of the autopsy results notify the appropriate community mental health center of the name of the parents of the Sudden Infant Death Syndrome victim.

Counselors who have received training in the Sudden Infant Death Syndrome will be available from regional mental health centers. Practicing physicians may wish to avail themselves of assistance in counseling from the center or continue with the counseling themselves.

*References upon request.

Treatment of Rheumatoid Arthritis with D-Penicillamine

Presented at the American College
of Physicians Regional Meeting
in Lincoln, Nebraska
March 11, 1978

CONVENTIONAL treatment for the patient with rheumatoid arthritis often involves only analgesics, antiinflammatory agents, appropriate rest and the usage of therapeutic exercises and splints for affected joints. Spontaneous remission is frequent enough that the initiation of complicated, expensive, and potentially dangerous drugs should be withheld until it is clear that progressive disease exists. At that point, chrysotherapy or less often immunosuppressives are sometimes beneficial in arresting the inexorable deterioration of joints that accompanies active rheumatoid arthritis.

D-Penicillamine or BB-dimethylcysteine is a penicillin analog which is capable of disrupting sulfhydryl bonds in vitro such as occur in IgM molecules which comprise the

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rheumatoid factor. Long used in the treatment of Wilson's disease and cystinuria because of its ability to chelate metals, D-Penicillamine was first used in the treatment of rheumatoid vasculitis by Jaffe in 1970. A gradual fall in the titer of rheumatoid factor was documented and many patients improved clinically. Inhibition of lymphocyte function rather than simple depolymerization of gamma-M rheumatoid factor was proposed as a mechanism of action due to the prolonged effect on serologic parameters long after the drug was discontinued.

In 1973 the Multicentre Trial Group undertook a one year controlled study comparing

D-Penicillamine to placebo and found a significant improvement in treated patients although most had longstanding and serious disease. More recently several independent studies have confirmed the efficacy of D-Penicillamine and in 1975 a "go low, go slow" regimen was suggested for patients with refractory rheumatoid arthritis because of the multiplicity of side effects documented in those studies. Benefit occurs only after several months and many patients fail to achieve a therapeutic dosage level because of toxicity. Most are reversible with discontinuation of therapy and include nausea, vomiting, anorexia, skin rash, stomatitis, alteration or loss of taste and proteinuria. Others are potentially serious and include lupus-like reactions, thrombocytopenia, polymyositis with or without the characteristic rash of dermatomyositis, hemolytic anemia, bone marrow aplasia, myasthenia gravis, mammary hyperplasia, Goodpastures syndrome, hirsutism and the nephrotic syndrome. The reported incidence of side effects requiring cessation of therapy is 25 percent. Several fatalities have been recorded and recently a neonatal death was attributed to a generalized connective tissue disorder in an infant whose mother was receiving Penicillamine.

We have initiated treatment with D-Penicillamine in a group of 81 patients with active, progressive and longstanding rheumatoid arthritis. All had failed to improve adequately with conventional therapy and most had previously failed to respond to chrysotherapy or immunosuppressives. A "go low, go slow" regimen was employed and patients were started at a dosage of 250 milligrams per day, increased to 500 milligrams per day after one month and finally at three months 750 milligrams per day was attained. No patients were treated with more than 750 milligrams per day but after response was achieved some were maintained at a lesser dosage. Patients with a prior allergic reaction to penicillin were not excluded unless it had been severe, particularly if exfoliative dermatitis had occurred. Weekly laboratory studies were obtained during the first 12 weeks of therapy, and included a complete blood count and platelet count, a urinalysis, and if

necessary 24 hour urinary protein and creatine phosphokinase were obtained at monthly intervals for the entire duration of treatment. After 12 weeks a complete blood count and platelet count were likewise obtained at monthly intervals. Sequential sedimentation rates, rheumatoid factor titers and if indicated serologic tests for lupus and liver function tests were obtained at appropriate intervals. All but two patients had adult onset rheumatoid arthritis and no patient was entered into the study if active disease has not been present for at least a year. Patients with stage IV disease were likewise excluded. A positive test for antinuclear antibody or positive LE prep did not contraindicate participation in the study, but an effort was made to exclude patients with evidence of other connective tissue diseases. Most patients were seropositive for rheumatoid factor at the start of treatment and had roentgenologic evidence of joint involvement. The average duration of disease activity was 10 years. Concomitant corticosteroids were allowed, but insofar as possible the dosage was held constant or reduced. Patients taking antimalarial drugs for at least six months were allowed to continue, but the dosage was not increased. Gold or immunosuppressives had been stopped at least three months prior to initiation of Penicillamine and all in this group had failed to respond to these agents. All patients were taking maximal doses of nonsteroidal antiinflammatory agents and these were continued throughout the study unless remission occurred, at which time these drugs were discontinued if possible.

Adverse side effects occurred in a substantial number of patients and were responsible for cessation of therapy in 25 of 81 or 30 percent, the usual reported incidence. Skin rash was the most common side effect and occurred in 10 patients, 9 of whom stopped the drug. One patient developed a severe bullous pemphigoid eruption which required treatment with steroids. Nausea occurred in 9 patients and required cessation of therapy in 7. Two were able to continue with lowering of their dosage. Stomatitis prompted discontinuation of the drug in 4 of 7 patients in which it occurred, but slight alteration or loss of taste was tolerated and cleared with continuation of

treatment. Significant proteinuria developed in six patients and levels of 15-22 grams protein in a 24 hour urine specimen were documented repeatedly in three patients. One patient developed a frank nephrotic syndrome with renal insufficiency requiring hospitalization and treatment with corticosteroids for a presumed immune complex nephropathy and lupus-like illness with the appearance of antinuclear antibodies and lowered serum complement. An additional patient developed a large pleural effusion while on treatment with Penicillamine which responded to moderate doses of steroids. A simultaneous skin rash necessitated discontinuance of Penicillamine and the exact nature of the pleural effusion was never ascertained. Modest neutropenia and thrombocytopenia were observed, though were not associated with any clinical difficulties and were corrected by lowering the dosage of Penicillamine. Microscopic hematuria was observed in one patient, but this disappeared with lowering of the dosage. Polymyositis with or without alterations of muscle enzymes has not been observed and we have not seen any alteration of liver function. In 2 patients the drug was stopped because of lack of response after 4 and 18 months, and in another the drug was stopped as she was moving out of town. An additional patient was removed from the study due to lack of cooperation.

Three patients sustained a complete remission allowing discontinuation of all other antiinflammatory agents. In one of these patients, persistent rheumatoid activity had been present for 15 years, and she had

required surgery to correct forefoot deformities as well as metacarpal interpositional arthroplasty. Fifty-nine patients experienced either excellent or modest improvement in their clinical status and in only 19 was there no evidence of any improvement whatsoever. However, 5 of these failed to tolerate the drug for the three months required to attain a maximal therapeutic dosage of 750 milligrams per day. Thirty-nine patients experienced a substantial fall in their sedimentation rates of 20 points or more. In eight patients the rheumatoid factor disappeared completely from their serum and in an additional 12 patients the titer of rheumatoid factor fell by two fold dilution or more. Seventeen patients were able to discontinue or reduce their dosage of steroids.

The addition of D-Penicillamine to the list of available drugs for treatment of chronic rheumatoid arthritis is now well established, although beset with many difficulties. Careful follow up and surveillance is mandatory as an every growing number of potential side effects are documented with increasing usage of the drug. There seems no doubt that D-Penicillamine alters the immune response in an as yet unknown way. A graduated dosage schedule allows the clinician to recognize early signs of toxicity but even with cessation of therapy some patients may continue to manifest toxicity and require additional supportive measures and even hospitalization. For this reason, it is essential that a cautious approach is followed and that all modes of conventional therapy be employed prior to initiation of treatment with D-Penicillamine.

How Serious Are We About Cost Containment?

IT seems as though pronouncements, news flashes, and even verbal indictments of the Health Care System regarding the high cost of medical care emanate from some level of government almost daily. Some of the more vocal elements name physicians as the major culprit in health care costs and its escalation. We physicians have been the target of these criticisms for so long that we tend to take them in stride and shrug them off with little reaction in a sort of they're-at-it-again attitude.

Perhaps it's time that we admit that the medical profession is at fault in some areas and set about doing something about them. It is easy for any one physician to say: "There are innumerable causes for the increased cost of medical care and there is very little that I can do about it or at best we physicians can impact only on 10-15% of the total cost and that hardly seems worth getting excited about and anyway why should I worry about it when Dr. Smith and Dr. Jones don't seem to care much about cost containment?"

Let's look at the problem objectively and honestly. 10-15% of 160, 180 or 200 billion is a lot of dollars no matter how you look at it. It may be a lot less than 70% of those total annual expenditures which Mr. Califano blames us for generating but it's still a lot of money. Perhaps now is the time for each of us to examine our own practice patterns to see where some savings could be effected. Does everyone with a G.I. complaint need a complete set of x-rays when first seen or can I make a clinical diagnosis and institute treatment on that basis and then x-ray only those who fail to respond satisfactorily. Are all the laboratory studies that I order strictly for the patient's benefit or are some of them for my own peace of mind and not necessary for the diagnosis or result in any alterations in therapy? Are daily EKGs necessary for the care of the acute M.I. patient or can sufficient information be obtained from the monitor and rhythm strips with less frequent

C. J. CORNELIUS, JR., M.D.
AMA Delegate

12 lead EKGs? Is it necessary to treat an arthritic shoulder or hip in physical therapy in a pneumonia patient that you wouldn't prescribe the same treatment for if he or she were not an inpatient? None of these questions are new or original but we are all aware of patients whose care could well have been less expensive if each one of us had asked ourselves questions like these.

So what else is new? The name of the game is **Cost Containment** whether we like it or not and to sit on the sidelines and say, let somebody else do it is to invite disaster. We can do something about cost and we must do something quickly or our chance may be lost. If the private practice of medicine is to survive, we must act individually and at once. We know that no National Health Insurance Program can contain cost unless it fixes physicians' fees (or places all physicians on salary) and institutes rationing of services. We know it but the general public doesn't and the idea of fixed fee schedules or salaried physicians appeals to a lot of people. These things have happened to our British and Canadian counterparts and they are a discouraged and disillusioned lot. It can happen here! It is happening here! It is as yet incomplete. Because of the reluctance of the people in this country to approve any new or expanded government program at this time, particularly one with a 180-200 billion dollar price tag, we may still have enough time to demonstrate our ability to make significant strides in containing cost, and to establish our credibility in this area. It is also necessary to make progress in cost containment if the private and prepayment health insurance mechanism is to survive. If increasing costs bankrupt the private insurance carriers or push the premium rates out of reach for most of our citizens then government will have no choice but to jump

in and fill the gap — and the bureaucrats are ready — believe me. I am afraid that too few physicians are willing to get involved in the cost containment business and if this is true then the physicians who follow after us must bear the consequences of our failure to act.

Dr. Tom Nesbitt, the new President of the AMA, in his inaugural address called on physicians to restrain fee increases by 1% per year in each of the next two years which will bring the increases in physicians fees in line with the increases in the cost of services in general. While this is a laudable endeavor it doesn't go far enough. If we are to do the job that needs to be done, we need to take a long hard look at virtually all of the procedures we do, and determine which of the possible settings or circumstances available is the most economical setting for the procedure. We must make an attempt to reverse the trend of patients using the emergency rooms in our hospitals for non-emergency medical services. Convenience is not reason enough to justify the increased

cost of outpatient services especially if the cost of such convenience is paid by a health insurance company or other third party carrier. You and I can and must do something about this trend. Minor surgical and diagnostic procedures done in the office result in much less cost to the system than the same procedure done in a hospital or surgi-center. Whenever possible we should return these procedures to the office.

These are but a few of the ways that we physicians can demonstrate our ability and willingness to participate in the business of cost containment. Cost containment activities of the NMA are being carried out by the Ad Hoc Commission on cost containment and its Parent Commission, and we can look forward to additional strategies and ideas from this Commission in the near future. Let us all take a new look at our practice habits and begin to apply some tincture of cost-containment whenever and wherever the opportunity presents itself and let's do it now.

Adolescent Health Knowledge Revisited

IN 1973 the Journal¹ published an article reporting that health knowledge among Nebraska high school seniors was lower than nationally standardized norms. This report is a second assessment of health knowledge of the state's adolescents, and discusses health knowledge among eighth graders. A newly developed and nationally standardized health knowledge test was used. Results of this investigation indicated that health knowledge scores of a sample of Nebraska's eighth grade students were similar to those achieved by a national sample, and that in only 3 of 11 specific health areas did the knowledge scores of students who had received instruction in those specific topics surpass the scores of students who had received no health instruction. Teacher training appeared to be an important variable associated with student achievement.

IAN M. NEWMAN, PH.D.

GARY L. MARTIN, PH.D.

ROBIN DARST, M.A.*

Department of Health Education
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Objectives of the Study

This study had three objectives: 1) to compare the health knowledge achievement scores of a sample of Nebraska junior high school student eighth graders with nationally established norms, 2) to compare achievement scores of students who had had a health education experience with those who had not, and 3) to compare the achievement scores of students taught by teachers with different teacher-training backgrounds.

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Instrumentation

The instrument used to assess the health knowledge was the American Association of Health, Physical Education and Recreation Cooperative Health Education Test form 3a, developed by the Educational Testing Service of Princeton, New Jersey. This test has a published reliability of .91 for males and .92 for females (KR-21) and a power of discrimination of .60 for females and .57 for males (item total by-serial correlation).

The Sample

1,148 eighth grade students (565 males and 583 females) from ten school districts including 13 schools completed this test. The sample does not reflect a truly random sample of the state involving only schools within 100 miles of Lincoln and including a disproportionate number of students from class A and B schools. Because larger schools usually have greater variety in their curriculum and are more likely to offer health related courses, it was assumed that if anything this sample would tend to score higher on this test than a truly random sample.

Results

Nebraska and National Scores: Table 1 shows that Nebraska eighth grade students' achievement scores essentially equal to those published as national norms.

Table 1
Standard Scores on the AAHPER Health Knowledge
Test for a Nebraska and National Sample
of Eighth Grade Students

	National Sample		Nebraska Sample	
	Male	Female	Male	Female
Mean Score	166	171	167	174
Standard Deviation	18	15	15	11
Median	170	175	172	176

Achievement Scores and Health Education Experience

Many Nebraska schools do not have a separate health class but cover their requirement to teach health through a variety of other courses. Students completing the health knowledge test were asked to indicate if they had had instruction in any of the 11 areas of health knowledge assessed by this test. The 11 areas were: consumer health, community health, diseases and disorders,

drug abuse, growth and development, international health, mental health, nutrition, personal health, first aid and safety, and sex education. The achievement scores for students who had health instruction in each of the areas were compared with students who had not. Only in the areas of mental health, sex education and first aid and safety did we find a significant difference in knowledge scores. The scores of students who had received instruction were significantly higher than those not having received instruction. No consistent differences were noted in the scores of males or females.

Reasons for the significantly better test scores of students who had received instruction in the areas of mental health, first aid and safety, and sex education could be many but we suggest they relate closely to the teachers' preparation to teach health. In the main, Nebraska teachers have not been well prepared to teach health. None of the teachers in the schools sampled had majored in health education. Yet, certain aspects of teacher preparation present a possible reason for the results of this study suggesting that better preparation and methods were used in the three areas in which higher scores were noted.

Mental health is a concern of all teachers and a topic covered in many ways in eighth grade classes. It is also an area for which student teachers in training and in continuing education programs receive considerable preparation. They are perhaps more competent in this subject than many of the others covered by the test used in this study. Sex education is an area of such controversy that it is likely that teachers willing to deal with this subject would clearly recognize the need to be well prepared and conduct well structured lessons. To do anything else would invite the wrath of those in the community who view such topics as being beyond the purview of the school. Similarly, the differences in first aid and safety scores may be the result of the fact that first aid is an area involving specific skills which can be practiced in class and which have immediate value to the student and for which the teacher must have

received special training and possibly even special certification.

Collectively these three areas of health instruction embody the basic components of a good educational program: well-prepared teachers, well-prepared lessons and students actively involved in the learning process. Each of these characteristics of a sound educational program is possible to achieve in the total health education program but difficult for teachers who have not had adequate health education preparation. Consumer health, personal health, diseases and disorders, growth and development, international health and drug abuse are all topics in which the average teacher receives little preparation unless he/she majors in health education.

Teacher Training and Achievement Scores

Who teaches health in Nebraska schools? Certainly not trained health teachers. The state's program to train degreed health educators is new and few graduates are yet teaching in the state's schools. Few schools see the need to hire trained health teachers and many school districts are so small as to make it economically impossible to hire specially trained teachers for specialty areas like health.

Other data gathered as part of this study indicate that teacher training was significant in determining how well students scored on this knowledge test. Students with teachers trained in the biological sciences scored highest, followed by students taught by registered nurses involved in the school health instructional program. These in turn were followed by students taught by physical education teachers and then, with the lowest average scores, students who were taught

health by social science teachers. These results are not surprising. Teacher training, as we suggested above, is important and it is unrealistic to expect teachers not training in health related areas to be effective health teachers.

Summary and Conclusion

Health knowledge among a sample of Nebraska eighth grade students appeared to be comparable to nationally established norms. Among those who had received health instruction as part of their school curriculum, significant knowledge gains were noted in only three of eleven areas tested. Students taught by teachers with a science background scored higher than those taught by teachers with other backgrounds.

Nebraska law calls for comprehensive health education in the schools of the state. A public educated about health and motivated to take more responsibility for their own health has been suggested as a way to help contain health care costs. National policy promotes health education as a vital part of an effective health care program. Programs in name only, however, lacking the basic investment to train and support competent health teachers will likely have little impact, as this study has suggested.

Acknowledgment

The information upon which this paper is based was collected pursuant to a grant from the Nebraska Regional Medical program. Mr. Robert Guthmann, Jr., assisted in the earliest stages of the project and his contribution is gratefully acknowledged.

Reference

1. Newman IM, Fuenning, SI: Adolescent health knowledge, Nebraska Med J (Nov.) 1973.

Down Memory Lane

1. The French have ever been in the van in Urology.

2. There are 32,042 miles flown daily with mail. Passenger service is fast becoming established.

3. Psychiatry alone can do very little in the field of prevention of delinquency, but in cooperation with the courts, child clinics, social service and welfare organizations, psychiatric studies and examinations are invaluable.

4. Out of the mouths of babes and sucklings shall also come buttons, safety pins, tennis rackets, or anything else that might have been lying around.

5. A study of Douglas County Hospital conditions soon revealed that inadequacies existing at present could be obviated only by the construction of at least two new buildings, a wing for the tuberculous and a structure for the better care of mental patients.

6. I made several trips on a slow pony 17

miles in the country when it was 12 below zero without leggings to protect my limbs and without a fur or other, heavy, overcoat. The bill amounted to \$18.00, to which the man strenuously objected.

7. The medical profession has been doing everything possible to elevate the standard of service to the sick — rich and poor alike — as shown by the increased requirements, for graduation from reputable medical schools, hospital internships for every graduate following his student days, and lastly, the highest quality of service to every patient in every hospital.

8. Laughter, then, has a real therapeutic value.

9. About one thousand American physicians attend clinics in Vienna each year.

10. Plastic surgery of the skin dates back to the time of the ancients, but it has not been until the last fifty years that it has become elevated to regular surgical practice.

Nebraska State Medical Journal
December, 1928.

President's Page

MERRY CHRISTMAS,
HAPPY HANUKKAH AND
HAPPY NEW YEAR

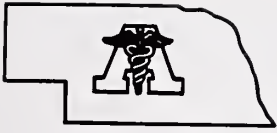
For most of us Christmas is a joyous reflective time of year. We are with family and friends. We remember the Christmas' past — when you received your very own first puppy and later the Magi-icle gift of perhaps a lovely ring to the most special person in the world.

At this time of year we may also look circumspectly to our various trials and tribulations — our successes and failures. Hopefully we continue to learn from our failures — why not the government? How simple life would be if we could replace the three wise men — Carter, Califano and Kennedy — with you, me and one of our friends. Not being able to succeed here one really might adapt the motto — "Blessed are those who expect nothing, for they shall not be disappointed." I do not believe American Medicine is quite ready to lie down and roll and its "soulful" eyes in this posture, so come join us in the chase for the brass ring — rainbow — or whatever; but please let us improve whatever we perceive to be a problem.



Happy Holidays to all of you and thank you for your help.

Houtz G. Steenburg, M.D.



The Auxiliary

LOVING IS BELONGING

What is this organization, the American Medical Auxiliary?

We are the spouses of physicians, with a legislative body, the House of Delegates, comprised of a National Board of Directors, State Presidents, and State Delegates allocated on the basis of number of members. A Board of Directors of elected and appointed officers meets between annual meetings of the House of Delegates. Committees, appointed annually as needs arise, give guidance to state and county auxiliaries.

All spouses of physicians may join, and by being members support the AMA and the medical profession. These physicians' spouses have a unique opportunity to become involved in health-related services in their communities.

Earlier this year, the Dodge County Medical Auxiliary had the privilege of hosting an area workshop on Membership and Health Promotion. Their guest speaker was Rose Gardner, First Vice-President and Membership Committee Chairman from the National office.

Guests included State and County officers and members, working together for the clout needed to be effective.

During the month of September, the State Officers and legislative chairman had the privilege of meeting with many county officers and members in the western part of the State. This gave us all an opportunity to share ideas on improving ourselves as members of the Medical Auxiliary. We heard how we can keep up to date on health-related legislative issues and programs to keep in personal contact with legislation.

We shared the need and ideas for fund raising for our own State Medical Education needs and the important part we play in health-related projects, such as programs for

the aging, health careers, immunization programs, helping combat child abuse, safety programs, and screening programs for vision and hearing.

As auxiliaries, we can have an impact on the image of the Medical profession by helping dispel some of its myths. We can help promote cost effectiveness by educating the people of our communities to be more responsible for their physical and mental health.

We can reemphasize the importance of preventive medicine, which will help control spiraling costs.

In her inaugural address, our new President, Mrs. Manuel Bergnes, says that "Consumers should be encouraged and assisted to learn healthful practices by educating and motivating them to adopt more healthful lifestyles, by exploring methods of utilizing public communication more effectively in health education efforts directed towards motivating consumers to adopt healthful lifestyles, and by encouraging consumers in appropriate risk groups to utilize professional, preventive health care services which would permit the early detection and treatment, or the prevention of illness."

As a physician's spouse you should take a personal interest in cost effectiveness. Be informed of your spouse's charge for services and know the hospital charges, so you know the facts and can answer people when you are challenged.

This energizing force, doing these things in our community, is volunteer power, and those volunteers are us, physicians' spouses and members of the AMA Auxiliary.

We must work together for happier, healthier living.

Helen J. Krause
First Vice President



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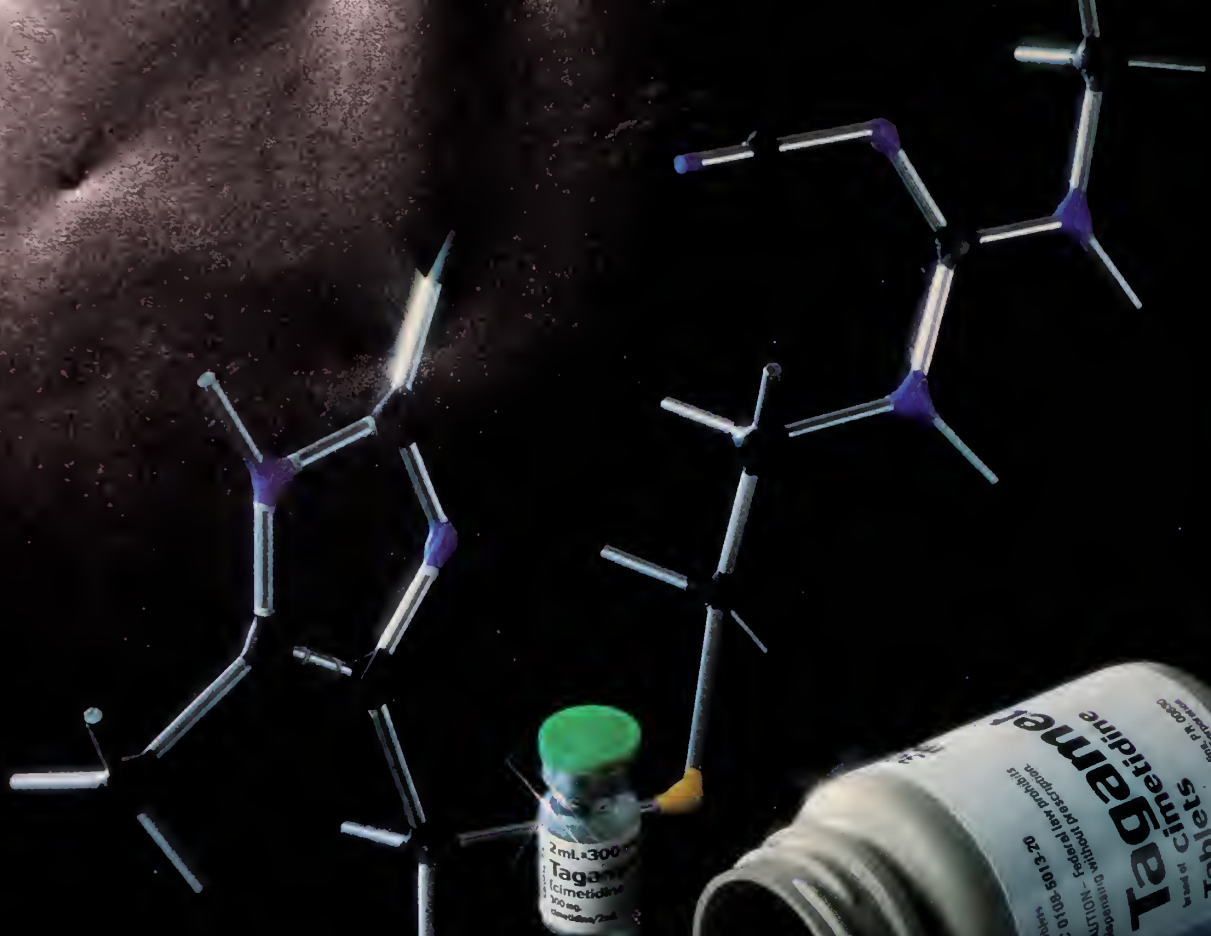
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 Dr. and Mrs. Floyd H. Shiffermiller
 Dr. Robert F. Park
 Dr. David C. Babbitt
 Dr. Khanh Quoc Nguyen
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Dr. Oliver J. Pogue
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 Dr. R. Q. Crotty
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 Dr. H. N. Vondrak
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 Dr. Joseph C. Scott, Jr.
 Dr. and Mrs. R. H. Meissner
 Dr. R. L. Grissom
 Dr. and Mrs. David Dyke
 Dr. and Mrs. W. Benton Copple
 B/Gen. and Mrs. P. A. Deffer
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Dodge County Medical Auxiliary
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Dr. and Mrs. David C. McMaster
 Dr. and Mrs. Robert L. Yekel
 Dr. and Mrs. Charles S. Wilson
 Dr. and Mrs. Jerry Cain
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 Dr. R. E. Penry
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 Dr. and Mrs. M. P. Brolsma
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70% of the medical community goal of \$150,000.00 to the Health Galleries has been raised!! Use the form below! **SEND YOUR PLEDGE TODAY!** (All donors from the medical community are listed in the monthly issues of the **Nebraska Medical Journal.**)



In accordance with the House of Delegates action* we give/pledge \$_____ for the development and maintenance of the Health Galleries.

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Name: _____

Address: _____

County Medical Society _____

For my pledge please send reminders _____ Annually _____ Semi-annually _____ Quarterly

★ October, 1976 Resolution for gift from each physician for \$200 to support the Health Galleries.

*Medicine*news

Dr. Heaney named.

Robert P. Heaney, M.D., Vice President for Health Sciences at Creighton University, has been named to a special committee by the Council on Dental Education of the American Dental Association. The purpose of the special committee is to review, analyze and make recommendations on the recently published report, **Dental Education in the United States — 1976.**

The dental curriculum study was supported by a grant from the W. K. Kellogg Foundation. As part of the study agreement, the Council indicated its intent that the study would be critiqued by a special study committee composed of several of the nation's leading representatives from higher education. The first meeting of the committee will be November 2 and 3 in Chicago.

Dr. Heaney was recently named President-

Elect of the Association for Academic Health Centers.

Robert Gerraughty appointed.

Robert J. Gerraughty, Ph.D., associate vice president for Health Sciences, has been appointed to two national committees interested in exploring international health care problems.

As a member of an advisory panel on Study of Middle East Regional Cooperation in Health, Dr. Gerraughty will assist in developing a position paper on health and nutrition in the Middle East. The committee is under auspices of the U.S. Public Health Service, office of International Health.

In addition, Dr. Gerraughty has been appointed to the Board on Science and Technology for International Development (BOSTID). BOSTID is part of the National Research Council, Commission on International Relations.

Picture Gallery



Distinguished Service to Medicine Award to Dr. Frank Cole. Neil Vanselow, M.D., Chancellor, University of Nebraska Medical Center; Frank Cole, M.D., Editor, Nebraska Medical Journal.



Distinguished Service to Medicine Award, presented to Frank Cole, M.D., by the University of Nebraska Medical Center. Left to right: Robert Koefoot, M.D.; Frank Cole, M.D.; Perry Rigby, M.D.

Our Medical Schools

Creighton announces family practice chairman.

Fred J. Pettid, M.D., has been appointed Chairman of the Department of Family Practice at the Creighton University School of Medicine. Dr. Pettid has been serving as acting department chairman since July, 1977, when Michael J. Haller, M.D., was named Associate Dean of Medicine.

Dr. Pettid received his baccalaureate and doctor of medicine degrees from Creighton University. He is a Diplomate and Fellow in the American Academy of Family Physicians.

Dr. Pettid has served as an assistant professor of Family Practice at the School of Medicine since 1971.

Rural health.

A rural health bridge of understanding is being formed between the University of Nebraska Medical Center and Nebraska communities.

The Medical Center's Student Rural Health Task Force is building the bridge through a series of projects to make health professions

students and western Nebraska communities more aware of rural health care needs and how they are being addressed by the Medical Center.

Formed last year by a handful of students who became instrumental in developing channels of communication between the communities and UNMC, the group plans to continue the ambassadorial work.

Last spring, group representatives visited eight communities throughout the state to present a slide-tape program on health career opportunities to high school students and learn first-hand about rural health problems from residents.

This year with almost 50 members, 30 of whom are first-year medical students, the group plans to visit as many communities and more if the demand is there.

The culmination of this year's activities will be a Rural Health Awareness Day in March. It will consist of a day-long series of seminars and lectures at the Medical Center followed by an evening convocation featuring nationally known rural health figures, such as Dr. Fitzhugh Mullan, director of the National Health Service Corps.

Books



Review of medical pharmacology; by Frederick H. Meyers, M.D., Ernest Jawetz, M.D., Alan Goldfien, M.D., and five other authors; limp cover \$14.50; 762 pages; published 1978 by Lange Medical Publications, Los Altos, California 94022.

This is the sixth edition of this book, which was first published in 1968. The three authors listed above and on the title page are associated with the University of California, San Francisco. The fifth edition appeared only two years ago, attesting to the newness of this text. The print is good, there is an index, there are figures and tables and an appendix; and there are references, which, however, are not numbered.

The book is divided into eight parts, and further into 66 chapters. It appears in German, Italian, Japanese,

Portuguese, and Spanish editions; and French and Chinese translations are planned. It is recommended.

F.C.

This is not a book, but it may be even better. It is a collection of toys, including nurses, doctors (I think), an ambulance, and all sorts of medical devices. It is intended to contribute to the delight of children, and it will do just that.

The company (the address I have is Schaper Manufacturing Company, P.O. Box 1470, Minneapolis, Minnesota 55440) was nice enough to send me the whole set. I kept the ambulance for my own collection; it reminded me of the nearly one thousand ambulance calls I made long ago. And I gave the rest of the collection to two granddaughters of a dear friend, and they are having a grand time with the figures and accessories, like stretchers, tables, lamps, and so on.

The set is designed to give pleasure to children, but it will certainly teach them, too. I like it; and I am keeping my ambulance.

F.C.

Between Cases

On Relativity.

Books are heavier than bricks.

T.C.

The Bedside Manner.

This brusque manner with seriously ill patients — a well-known trick.

Schnitzler: Dying.

Medical Story.

The doctor's here, sir.

I can't see him. Tell him I'm sick.

Anon.

Heard On TV.

It was continulous.

The Steno Pool.

Wait, don't go so fast, I'm rustic.

You mean rusty. Rustic means living on a farm.

Well, I do live on a farm.

No comment.

Section On Veterinary Medicine

A whale's pulse rate is 9 per minute.

Department Of Blood Pressure.

140 vitriolic and 80 diabolic.

Section On Calories.

Celery is said to have minus calories. It

takes more calories to chew the celery than the celery has in it.

Clerihews.

Sir Humphrey Davy

Abominated gravy

He lived in the odium

Of having discovered sodium.

Anon.

Something We Can't Do.

It's hard to make an asymptomatic patient feel better.

C & C.

Section On Appearances.

The patient appeared in person.

I did, too.

Quote Unquote.

Big surgeons make big incisions.

H.A. Olgin, M.D.: The Doctor Game.

Words I Can Do Without.

Kudos, scrivener, protean, seminal, compartmentalized.

Quote Unquote.

Never named sickness.

Emerson.

—F.C.

Coming Meetings

AMERICAN MEDICAL ASSOCIATION — Interim Session, House of Delegates, December 2-6, 1978, Palmer House, Chicago, Illinois.

AMERICAN MEDICAL ASSOCIATION — Winter Scientific Program, December 7-10, 1978, Las Vegas, Nevada.

RADIOLOGY OF THE ACUTELY ILL AND INJURED PATIENT — UPDATE 1979; January 26-27, 1979; Stouffer's Hotel, Greenway Plaza, Houston, Texas. Presented by The University of Texas Medical School at Houston, Department of Radiology. Co-sponsored by The University of Texas Health Science Center at Houston, School of Allied Health Sciences and Division of Continuing Education. Fee: \$150.00; write to: Division of Continuing Education, The University of Texas Health Science Center at Houston, P.O. Box 20367, Houston, Texas 77025. This course meets the criteria for 14 credit hours in Category I of the Physician's Recognition Award of the American Medi-

cal Association, provided it is used and completed as designed. Application has been made to the American College of Emergency Physicians for 14 ACEP Category I credits, and to the American Academy of Family Physicians for 14 Prescribed credit hours.

NEBRASKA MEDICAL ASSOCIATION — Annual Session, April 29 - May 2, 1979, Holiday Inn, Kearney, Nebraska.

ROCKY MOUNTAIN NEUROSURGICAL SOCIETY — The Forteenth Annual Meeting will be held at the Jackson Lake Lodge, Jackson Hole, Wyoming, June 13-17, 1979. Write to: Ralph J. Kaplan, M.D., Secretary, University of Oklahoma Health Sciences Center, P.O. Box 25606, Oklahoma City, OK 73125.

AMERICAN MEDICAL ASSOCIATION — Annual Convention, July 22-26, 1979, Chicago, Illinois.

In Memoriam

*By medicine life may be prolong'd
yet death*

Will seize the doctor too.

—Shakespeare

DR. MAX W. KINNEY

Doctor Max W. Kinney died on June 4, 1978, at the age of 50. Doctor Kinney was

born in Mound City, Missouri, on April 27, 1928.

He graduated from the University of Nebraska College of Medicine in 1955. Doctor Kinney studied orthopedic surgery at Barnes Hospital in St. Louis, and following a practice in Council Bluffs, he moved to Omaha in 1970.

Survivors include his wife, Mary Ann; six children, Ann, Paul, Greg, Liz, Mary Kay and John; a brother, Jack Kinney of Santa Anna, Calif.; and his mother, Lela Kinney of Mound City, Missouri.

Physicians' Classified

Advertisements in this column are run at a rate of twenty cents per word with a minimum of \$10.00 per insertion. Copy must be received by the fifth of the month preceding date of publication and should not exceed 50 words. Each advertisement will be taken out following its first appearance unless otherwise instructed. Where numbers follow advertisements, replies should be addressed in care of The Nebraska Medical Journal, 1902 First National Bank Building, Lincoln, Nebraska 68508.

MEDICAL DIRECTOR — General practitioner to perform general examination, care, and treatment of patients at state psychiatric hospital. Forty-hour week with rotating on-call duty. No surgery. Starting salary of \$41,000 to \$45,000, depending on experience. Excellent benefits. Contact: H. D. Herrick, M.D., Superintendent, Norfolk Regional Center, Box 1209, Norfolk, Nebraska 68701. Call Collect: 402-371-4343.

OPPORTUNITY IN FAMILY PRACTICE. Two Board Certified Family Physicians need third physician. New office connected to new hospital (250 beds) with all ancillary and specialized services available. Any interested physicians please sent curriculum vitae to Link, Chapman & Associates, Inc., 1515 West Truman Road, Independence, Missouri 64050, or call collect 816-836-8200; 9:00 A.M. to 4:30 P.M.

NEBRASKA: New Hospital Emergency Department ready to expand to full-time coverage. Hours Monday-Friday; no weekends. Two physicians needed for week day/night Emergency Department coverage. Excellent Income plus benefits. Contact: Box #65, NEBRASKA MEDICAL JOURNAL, 1902 First National Bank Building, Lincoln, Nebraska 68508.

OMAHA — St. Joseph Hospital area. Live on a 4½ acre estate in an 1885 house; walk, bicycle, or take the bus to work. Stained glass windows, ornate woodwork, fireplaces, parquet floors, private parking, and vegetable garden on grounds. Two bedroom apartments \$275.00 — heat and hot water supplied. Also have lofts in the Old Market close to Lutheran Hospital, 1300-1600 square feet — \$300.00. Call Mercer Management Company, 1016 Howard Street, Omaha, NE 68102. Telephone: (402) 346-4445.

PSYCHIATRIC RESIDENCY: Vacancies for PG2 through PG4 positions starting January 1, 1979, through July 1, 1979. For those eligible for an Iowa Residents License via the ECFMG receive stipends of: 1st year, \$21,294; 2nd year, \$22,360; 3rd year, \$23,478. Those eligible for a regular Iowa license via FLEX or reciprocity receive stipends of: 1st year, \$23,478; 2nd year, \$24,648; 3rd year, \$25,896. Prepare for a career in private practice, community clinics or hospital based psychiatry. Emphasis on close supervision of intensive individual and group psychotherapy, OPD, Children's Unit, Adolescent Unit. Neurology affiliation with University of Iowa. Intensity of training program appreciated best by personal visit. T. B. McManus, M.D., Superintendent, Mental Health Institute, Cherokee, Iowa 51012. Call collect 712-225-2594. Equal Opportunity Employer.

12-78

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COLACE[®]
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Colace means escape—from laxative stimulation, from laxative harshness, from laxative habit. Colace gently helps soften stools for easy, painless, unstrained elimination. It's the great laxative escape, from infancy to old age. Available in 100 and 50 mg. capsules. Syrup or liquid.

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COMPATIBILITY



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

- 1 For the relief of symptoms associated with cerebral vascular insufficiency
- 2 In peripheral vascular disease of arteriosclerosis obliterans, thromboangitis obliterans (Buerger's Disease) and Raynaud's disease

Final classification of the less than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted. Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose, Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose, Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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VASODILAN[®]

(ISOXSUPRINE HCl)
20-mg tablets

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WashingtonNotes

The Congress & us.

The 95th Congress frantically adjourned leaving dead most of the Carter Administration's major health proposals.

The leading casualty among the health bills was a hospital cost containment measure. Unexpectedly gaining Senate passage in a watered-down fashion late in the session, the Administration and its congressional leadership pulled out all stops to whisk it through the House. But strong opposition by a number of House members who refused to be stampeded, and the concerted effort of the AMA, the American Hospital Association, and other health groups kept the President's much wanted measure from passage.

The rebuff to the Administration was a smashing victory for health care providers, including the AMA, and was especially sweet to the nation's hospitals which had been subject to bitter tirades from Health, Education and Welfare Secretary Joseph Califano. "Obese," "lazy," "bloated" were adjectives hurled at the hospitals by Califano, who also labelled the Voluntary Effort (VE) to bring down hospitals' costs as a sham.

An angry confrontation took place on Capitol Hill when the AMA met head-on with Sen. Edward M. Kennedy's (D-Mass.) proposal for national health insurance (NHI). The AMA charged that the Kennedy-Labor scheme for NHI would bring about total federal domination of health care in this country.

William Felch, M.D., chairman of the AMA Council on Legislation told Kennedy:

"The total federal takeover of the health care system is inescapable under this program. In our opinion we do not think the American public will want its health care directed and controlled by the federal government. The history of federally run programs does not instill such trust and confidence as to support such action."

The heart of the Kennedy-Labor proposal

sets national maximum budget levels of expenditures for health care together with similar maximum areawide and state budgets. Hospital budgets and physician fee schedules would be negotiated annually.

This budgeting process would be controlled through a new federal agency called the Public Authority.

Dr. Sammons, executive Vice President of the AMA, told Kennedy that the AMA shares the concern of proponents of NHI proposals that health care should be available to all persons. He pointed out that the AMA developed a bill in the 95th Congress — the Comprehensive Health Care Insurance Act — that provides comprehensive and catastrophic coverage for all persons, and is founded on the strengths of its existing health system.

The AMA witnesses' appearance was marked by several sharp exchanges with Kennedy. The Senator took issue with Dr. Sammons' statement that Kennedy's bill would result in a total federal takeover. The witness suggested that Kennedy read his bill again.

Kennedy also complained about the AMA assertion his bill would lead to rationing of health care. Dr. Sammons replied that when fixed budgets and ceilings are established coupled with increased demand, somewhere along the line there will be people who are not receiving services.

The administration & labor.

HEW Secretary Califano refused to accede to Labor's demands that the Administration tailor its NHI plan to Labor's scheme. The crucial difference is Labor's insistence that NHI be implemented at once; the Administration wants it done in stages.

Califano earlier told the Senate Human Resources Subcommittee that: "The President believes that a program this complex — affecting the nation's third largest industry

which employs six percent of the entire work force and having profound implications for federal, state, and local budgets — must be phased in with singular care and sensitivity to the economy, governmental budget and the administrative complexity of the health care system.”

Califano also indicated the Labor-Kennedy plan would be too costly, pointing to the \$30.8 billion addition to the federal budget by 1983 contemplated by the plan, a figure soft-pedaled by the Labor forces.

Carter, inflation, & us.

President Carter has singled out the health care sector for special attention in his new wage-price guideline plan to dampen inflation. While calling for the economy as a whole to decelerate wages and prices by one half of a percentage point, the chief executive said the increase of medical care costs should drop by two percentage points per year.

“The most important step we can take is to pass our bill to control hospital costs,” Carter said in his nationwide address. Noting that the Senate this year passed a version of the controversial hospital cost containment program, Carter said “next year I will try again, and I believe the whole Congress will

act to hold down hospital costs — if your own members of Congress hear from you...”

In a White Paper on the anti-inflation program, Carter said that voluntary actions of the medical care industry have moderated the rate of medical care inflation. He was referring to the Voluntary Effort led by the AMA, AHA, and the FAH which has succeeded in bringing hospital rate of increase down more than two percent compared with the rate a year ago.

How many doctors.

The supply of physicians will be more than adequate to meet the nation's needs by 1990, according to a government study.

“Tremendous increases in health manpower supply (may) bring supply and requirements for most health professions more nearly into balance than at any time in the nation's recent history,” said the report on the Status of Health Professions Personnel in the United States, prepared by the Department of HEW.

Physician supply is expected to rise from 379,000 in 1975 to almost 600,000 in 1990. The ratio of physicians to population is projected to rise from 177 per 100,000 people in 1975 to 241 per 100,000 in 1990.

REPORTS OF OFFICERS, DELEGATES AND COMMISSIONS

FALL SESSION

September 22, 23, & 24, 1978

REPORT OF THE BOARD OF DIRECTORS

Houtz G. Steenburg, M.D., Aurora, Chairman; Charles W. Landgraf, Jr., M.D., Hastings; Orin R. Hayes, M.D., Lincoln; Arnold W. Lempka, M.D., Omaha; Russell L. Gorthey, M.D., Lincoln; Allan C. Landers, M.D., Scottsbluff; Frederick F. Paustian, M.D., Omaha; Harry W. McFadden, Jr., M.D., Omaha; Carlyle E. Wilson, Jr., M.D., Omaha.

The Board has considered a lengthy agenda at each of its meetings, since the Association's reorganization, encompassing subjects formerly distributed between the Board of Directors and Policy Committee. In this report, the Board will present items of both an informational nature and those proposing action by the House of Delegates.

(1) (Informational Item) The Headquarters Office of the Association will move to the fifteenth floor of the First National Bank Building late this year or in early 1979. The new facilities will provide an enlarged conference room area and additional work room space, both much needed as the activities of the Association continually expand.

(2) (Informational Item) The Board has closely monitored the development and approval of the revised regulations and standards for Nebraska hospital licensure working closely with the Nebraska Association of Pathologists. The laboratory section of the document was modified several times, however the wordage preferred by the Association was adopted by the State Board of Health at its August, 1978 meeting.

(3) (Informational Item) The financial situation of the NEBRASKA MEDICAL JOURNAL has received special attention by the Board and the feasibility of a multi-state publication or publishing a Journal at a frequency less than monthly is being explored. At this point, the Board has no specific recommendations to make regarding the Journal.

(4) (Informational Item) The Board considered the second opinion surgery mechanism implemented by the Medicare intermediary and developed a position statement which was distributed to NMA members in a newsletter dated August 15, 1978. The Board did not feel it could support an activity which had not been proven to be cost effective. The Board did recognize the value of consultation activities which take place in the day-to-day practice of medicine, and have always been a part of Nebraska medicine. Participation in the program was left to the discretion of the individual physician.

Second Opinion on Surgery

The Board of Directors of the Nebraska Medical Association has prepared a statement in response to the recently announced second surgical opinion program by HEW. For the information of Association members, the statement is as follows:

"Several months ago, the Department of HEW

decided to launch a second surgical opinion program as a part of the Department's overall effort in containing costs.

"Two limited demonstration projects (New York and Michigan) costing about a million dollars, are barely under way after the better part of a year's negotiation and planning, but the Health Care Financing Administration of HEW has gone ahead in the face of these obvious warning signs and started a nation-wide program. There is no evidence that this hastily conceived complex bureaucratic scheme will be cost effective. Indeed, delaying treatment, administrative expenses as well as paying the additional consultant fees, it would seem, would increase the cost of care.

"The NMA has always favored surgical consultation when in the patient's best interest and continues to do so, but cannot support a scheme providing poor care in exchange for an envisioned cheaper rate.

"The individual surgeon may follow his own conscience about participating as a consultant in private or federal second opinion programs, but the NMA cannot formally support a federal program established in defiance of strong American Hospital Association, American Medical Association and American College of Surgeons advice against implementing such an activity."

(5) (Informational Item) The Board considered and endorsed the recommendation of the Commission on Medical Education that the Lancaster County Medical Society/Lincoln Medical Education Foundation application for Category I CME accreditation to be given provisional accreditation for two years and that this recommendation be forwarded to the LCCME for final action.

(6) (Informational Item) The Board considered the Association's membership in an organization entitled "Aces and Deuces" which is comprised of states having one or two delegates to the AMA House of Delegates sessions. The organization functions at sessions of the House of Delegates sponsoring a breakfast for all states' delegates at one AMA meeting and a luncheon at another. It was felt by the Board, as has been the case in several other states, that the return to the contributing states is not sufficient to warrant the annual payment of \$150. The Board decided to terminate membership in the organization in light of the fact the NMA does participate in the North Central Medical Conference which provides a hospitality suite at interim meetings of the AMA House of Delegates.

(7) (Informational Item) The Board considered the recommendation of the Scientific Sessions Committee and the Commission on Clinical Medicine that exhibits at the NMA Annual Session be dropped and that companies and organizations be asked to contribute through a grant mechanism thereby allowing more flexibility in planning as well as allowing greater emphasis on development of the scientific content of the program. The recommendation that a registration fee be implemented was also considered. The Board adopted the position that the NMA dispense with exhibits at the 1979 Annual Session and substitute this activity with the opportunity for companies to provide grants which would be appropriately acknowledged. The Board also adopted the position that a \$25.00 registration fee be assessed at the 1979 Annual Session.

(8) (Informational Item) The Board considered a request that it subsidize house staff/resident delegates to sessions of the AMA House of Delegates. The Board discussed this matter in detail and determined the

Association should not provide a subsidy inasmuch as these individuals are not representing the NMA, but rather are primarily representing the resident physician. The fact that they come from Nebraska is incidental. The Board did reiterate its position encouraging participation in NMA and county medical society activities by residents. The Board recognized there are currently only 31 house officer/resident members of the NMA and 94 student members.

(9) (Informational Item) The Board is in the process of looking for a lobbyist to cover the 1979 Session of the Nebraska Legislature. Our past arrangement with Nebraska Blue Cross-Blue Shield will not be renewed for the coming year. Your Board hopes to complete its review of this matter and select a lobbyist in the very near future. An announcement will be made to the membership as soon as an individual has been selected.

(10) (Informational Item) The Board considered a request from a representative of the Nebraska Society for Internal Medicine that the NMA consider supplying staff and administrative support to this specialty society. At various times in the past, this subject has been considered by the NMA, and the Board decided to study the matter further and determine the feasibility of providing service to the internal medicine group as well as other medical organizational bodies that might have a similar interest, on a cost plus basis. Several states do provide a service of this type noting that the communication aspects of such an arrangement can be beneficial to all groups involved. Other Nebraska specialty societies will be contacted to determine their interest in such a service.

(11) (Informational Item) The Board discussed in detail the beneficial aspects of developing a working relationship with Nebraska's medical schools. Initial discussion has been held with the University of Nebraska Medical Center and the Board will meet with Creighton University School of Medicine representatives in the near future.

(12) (Informational Item) The Nebraska Delegates to the AMA have been extended an invitation to caucus with the Delegates from Oklahoma and Kansas. In conversation regarding this, they were informed that at this time our loyalties must lie with the North Central Medical Conference, but perhaps it would be well for our Delegates and Alternate Delegates to further explore this invitation. This matter has not been discussed by Nebraska Delegates to the AMA and any further action will depend on such discussion.

(13) (Informational Item) The Board considered the results of a recently completed physician/population study. This NMA effort revealed that (based upon 1978 estimated population figures) since 1970, 26 counties have had a loss in population and 23 counties had a subsequent loss in physician population. While 63 counties have gained in population, only 29 counties have recorded an increase in physician population. While three counties had no change in population over the eight-year period, 40 counties have had no change in physician numbers. It should be noted for comparison purposes that between 1950 and 1970, 70 Nebraska counties had a decrease in population and only 23 had an increase in population. In 1970, there were 1592 physicians in Nebraska, while in 1978 there are 1810. 114 of the 1810 physicians are retired and/or not in practice. There are 115 hospitals in Nebraska. Records indicate there are 15 counties in which there are no physicians. Of the 160 counties, 75 or 27.9% are under age 40; 900 or 56.2% are 40 or over. 248 or 14.5%

are over age 60 and ages were not available for the remaining 4.8% or 82 of Nebraska's practicing physicians. The study further relates there are 11 counties (11.8%) with a physician to population ratio of 1 to 1000 or less; there are 19 counties (20.4%) with a physician to population ratio of 1 to 1001-1500; there are 13 counties (14.1%) with a physician to population ratio of 1 to 1501-2000; there are 11 counties (11.8%) with a physician to population ratio of 1 to 2001-2500; there are 7 counties (7.5%) with a physician to population ratio of 1 to 2501-3000; there are 17 counties (18.3%) with a physician to population ratio of 1 to 3000 and over; and that the 15 counties with no physician manpower constitute 16.1% of the counties, when considering the number of counties in each population category having a physician. It can be noted the counties having a physician/population ratio of less than one physician to 1000 population comprise 54.7% of Nebraska's population. The counties having a ratio of one physician to 1001 to 1500 population comprise 14.2% of Nebraska's total population. The counties reflecting a ratio of one physician to 1501 to 2000 population comprise 10.6% of Nebraska's population. The counties reflecting a ratio of one physician to 2001 to 2500 population represent 5.5% of Nebraska's population. The counties having a ratio of one physician to 2501 to 3000 population represent 3.8% of Nebraska's total population. The counties having a ratio of one physician to 3000 or more population represent 9.6% of Nebraska's total population and the counties having no physicians represent 1.6% of Nebraska's total population or an actual count of 25,369 citizens. The study indicated there are 55 Nebraska counties in which there are generalists or family practitioners and 23 counties in which there are in addition specialists. The study revealed there are 1364 physicians in private practice; 38 physicians in fulltime VA work; 29 physicians in fulltime emergency room work; 16 physicians in fulltime Department of Public Institutions work; 13 physicians in fulltime administration; and 245 physicians in fulltime medical school faculty activity. The physician/patient ratio state-wide was 1 - 938 in 1940; 1 - 928 in 1950; 1 - 937 in 1960; 1 - 1064 in 1972; 1 - 955 in 1975 and 1 - 927 in 1978. Residents in training were not included in this survey. Future statistical analyses will include these licensed physicians and by so doing have a demonstrable, beneficial affect on certain phases of the data.

(14) (Action Item) Your Board spent considerable time during the interim studying Association finances. At its August meeting, the Board adopted a motion to utilize surplus funds in 1978 and 1979 to supplement the Association's reserves to a point where they equal one year's operating expenses. This action was in keeping with the request of the House of Delegates that the Association maintain a one-year operating fund in reserve. While the Board is happy to comply with the wishes of the House, it does wish to point out the transfer of surplus income to the permanent reserves will diminish the period of longevity that might be expected because of the recent dues increase. This action will necessitate approximately \$160,000 being transferred in the next several years to the permanent reserves. Subsequently, each year thereafter income will be transferred to the permanent reserves to keep pace with the growth of the yearly budget.

The Board further discussed, but took no final action regarding the policy of further dues increases. There are two options available, one using the leap frog approach of an occasional dues increase (usually requiring a \$30.00+ increase) or the incremental

approach such as pre-planned increases in dues on a more frequent basis, i.e. (\$15.00 every two years). The Board will continue to review this matter and report to the House its recommendation for meeting the financial needs of the Association. Hopefully, this can be done at least one year prior to the need for any further dues increase. At the present time, your Board feels the Association is in good financial condition and barring any unforeseen expenditures of large amounts of funds, recommends no change in the dues structure for 1979.

The Board recommends the House of Delegates encourage all County Medical Societies actively recruit non-members. There are approximately 200 such individuals in Nebraska at the present time. The additional participation and income can only serve to benefit organized medicine at all levels. A listing of non-members is available from the Association Office.

(15) (Action Item) The Board considered the vacant position of Vice Speaker and its responsibility to fill vacancies occurring in any Association office subject to the approval of the House of Delegates at its next session. The Board selected Doctor Alvin A. Armstrong of Scottsbluff to serve as Vice Speaker and submits this action to the House for approval.

(16) (Action Item) In 1976, American Health Profiles Inc. of Nashville, Tennessee, sold its services to Farmland Industries. The service represents a 30-minute screening process carried out for a fee of \$60.00. The service is available in traveling vans manned by three technicians and a registered nurse. They provide for chest x-ray, pap smear, breast exam, SMA 24, etc. The result of the computerized data is sent to the attending physician.

This service is about to be "offered" again.

Needless to say, we have no answers to the question of cost justification for these "routine check-ups," but we do need to know that the testing is performed by competent people using accepted, safe and reliable technical methods under proper conditions and with the upmost adherence to quality control.

The Board of Directors will meet with a field representative for the co-op health screening program during this Fall Session of the House of Delegates and a further oral report will be presented to the House.

(17) (Action Item) The organizational meeting of the Western Physician Purchasing Association was held in Denver, August 11, 1978.

Its purpose is to provide a joint purchasing service for professional and office supplies to individual physician members of the constituent state association. WPPA will negotiate with various suppliers and attempt to secure favorable discounts through the promise of volume purchases from its participating members. Actual purchase transactions will be between individual physicians and the particular suppliers with whom WPPA has negotiated.

The advantages of participation in the WPPA program will be available to the members of the constituent medical association. It will be entirely voluntary and an individual physician will be free to participate or not as he chooses.

Legal opinion has been sought regarding anti-trust principles and the attorneys feel they do not apply.

Formal opinion has been sought from the Federal Trade Commission.

Pending a favorable FTC response, the Board

requests approval to implement this program when complete legal clearance is given by NMA legal counsel.

The Board presents this report and its actions to the House of Delegates for adoption and stands ready to consider any additional matters the House may refer to it at this session.

Respectfully submitted,
HOUTZ G. STEENBURG, M.D.
Chairman

REPORT OF DELEGATE TO THE AMA 1978 ANNUAL MEETING

The 127th Annual Convention of the American Medical Association was held in St. Louis, Missouri, June 18th through 20th. John H. Budd, M.D. of Cleveland, Ohio used this quotation from Abraham Lincoln when referring to the report of the National Commission on the Cost of Medical Care. "The Dogma of the quiet past are inadequate to the stormy present. The occasion is piled high with difficulty and we must rise with the occasion. As our case is new, so we must think anew and act anew."

This session of the House of Delegates marked the first time in the history of the American Medical Association that direct delegates from the specialty societies, some 49 of them, were seated as official delegates. The volume of business considered at this session set a new all time record with 72 reports, one of which contained over 50 recommendations, and 169 resolutions accepted as official business of the House.

The theme of the convention was Cost Containment and the 48 recommendations of the National Commission on the Cost of Medical Care were considered individually in the reference committee hearings with 17 of them being approved outright, 14½ given qualified approval or approval in principle, 16½ referred to the Board of Trustees for further study and report. (Approved: 1, 2, 4, 10, 13, 17, 18, 24, 26, 27, 31, 32, 34, 41, 44, 45, and 46. Qualified approval: 3, 6, 7, 9, 11, 12, 14, 16, 20, 29, 30(B), 38, 39, 47, and 48. Referred to Board of Trustees: 5, 8, 15, 19, 21, 22, 23, 25, 28, 30(A), 33, 35, 36, 37, 40, 42, and 43.)

Nebraska Resolution #56, encouraging the AMA to coordinate its Health Education (of the public) Efforts with state, local, and specialty societies as well as public and private organizations, was considered with several related resolutions and the concept included in an amended Resolution #47 which reads as follows:

RESOLVED, that the American Medical Association continue to augment the leadership role of the medical profession in developing and promoting health education materials and programs to motivate Americans of all ages to maintain more healthful lifestyles and to assume more responsibility for the maintenance of personal health; and be it further

RESOLVED, that the AMA continue to cooperate in the coordination of efforts in the public and private sectors to make health education more effective; and be it further

RESOLVED, that the American Medical Association explore ways to assure more effective dissemination and sharing of effective efforts to develop and promote health education information and materials.

Nebraska's Resolution #57, which called on the AMA to outline the factors responsible for the increasing cost of medical care, was referred to the Board of Trustees for study and implementation.

Nebraska's Resolution #58, which directed the AMA to "request that the Federal Government refrain from implementing further regulations and health care systems unless these have been proven to decrease health care costs while improving care" was approved in amended form which read following the words "health care systems," "without supporting evidence of positive impact upon quality of care and cost containment, or positive impact upon quality of care alone."

The "sleeper" of the Convention had to be the approval of a Kansas substitute recommendation to Reference Committee B's proposed referral of 5 resolutions regarding the AMA's sponsored HR 1818 and S 218 (NHI proposal) to the Board of Trustees by adding the following, "with instructions to determine if a new or substitute bill for HR 1818, Comprehensive Health Insurance Act of 1977, is necessary or not; and, if an AMA sponsored National Health Insurance bill is to be submitted at the interim meeting it should be circulated to the members of the House of Delegates as early as possible so it may be studied in detail before that session."

The House approved a proposal to extend participation in Social Security (OASDI) to government officials and employees and other exempt individuals and went on record supporting an amendment to the U.S. Constitution prohibiting deficit spending.

The proposed revision of the AMA's Principles of Medical Ethics was sent back to the Judicial Council for reconsideration when considerable opposition to the revised draft was encountered from a number of states. An Ad Hoc Committee was appointed by the Speaker of the House to meet and deliberate with the Judicial Council regarding the Principles of Medical Ethics and related items. Resolution #28, which stated that any cost containment recommendations or activities adopted by the AMA be applied equally to State and Federal Hospital Programs was approved. Substitute Resolution #18 was approved which called our physicians to continue to act as non smoking exemplars to discourage smoking in public pronouncements, educational programs, and discourage visual presentations which depict smoking as the norm in American culture. It further recommended the elimination of cigarette sales and smoking in medical and health care facilities.

Last but not least, the House approved an amended Resolution #38 which reads as follows:

RESOLVED, that the American Medical Association urge the Congress of the United States to demonstrate its sincerity in reaching its objectives to curtail rising costs and galloping inflation by initiating a voluntary cost containment program to effect an annual two percent (2%) reduction in the rate of the expense of running Congress; and be it further

RESOLVED, that the AMA urge Congress to foster and promote the implementation of a voluntary cost containment program to effect an annual two percent (2%) reduction in the rate of the expenses involved in running all federal departments, bureaus and agencies.

Guess how much publicity this action was accorded in the news media and how far it will go towards implementation in the Congress?

I consider it a privilege to represent the Nebraska Medical Association in the AMA and welcome the comments, suggestions, and criticisms of any member of this House of Delegates as he deems appropriate.

Respectfully submitted,
C. J. CORNELIUS, JR., M.D.
Delegate

REPORT OF THE EXECUTIVE DIRECTOR

Considerable time has been spent during the interim between House of Delegates meetings in implementing the new organizational structure of the Association as approved by the House of Delegates.

The "shake down cruise" appears to be functioning well and all Commissions have met and begun their work as outlined in the Articles and By-Laws.

Reports from the Commissions with their recommendations will be identified by subject matter in the Handbook index under the main heading of each Commission.

STATE LEGISLATURE: The forthcoming 1979 session of the Nebraska Legislature will be ninety days in length and will provide the Association with a proportionate number of bills to review and determine appropriate action.

This being an election year, we can expect to see a number of new faces among the forty-nine Senators. At this time, it would appear that possibly nine new Senators will be making their appearance in the '79 session, representing an approximate 18% turnover in that body.

Local contact with Senators is still the key to good communication and a successful legislative program. As in the past, members will be contacted by the appropriate individuals to assist in contacting the Senators on matters of interest to the Association. Another busy session can be anticipated.

NORTH CENTRAL CONFERENCE: The 1978 session of the North Central Medical Conference has been scheduled for October 28 and 29, 1978, at the Raddison South Hotel in Bloomington, Minnesota. The conference consists of Nebraska, North and South Dakota, Iowa and Minnesota. An excellent socio-economic program is being prepared for this two-day session and all members are invited to attend. Information regarding reservations can be obtained from the Headquarters Office.

ANNUAL AND FALL SESSION: The 1979 Annual Session will be held at the Holiday Inn, Kearney, Nebraska, on April 29, 30, May 1 & 2.

The 1979 Fall Session of the House of Delegates and the Board of Councilors will be held in Lincoln, at the Lincoln Hilton on September 27-29, 1979. This date coincides with a Nebraska home football game.

The Board of Directors report recommends discontinuance of exhibits at the Annual Session and if approved by the House, this action would be implemented at the Kearney meeting. One advantage to such an arrangement is additional options regarding hotel selection because of reduced space needs. Other states that have taken similar action indicate little problem in obtaining grants from exhibitors for their scientific program.

MISCELLANEOUS: This past April, I attended a week-long seminar on the Canadian Health System in Ontario as a member of the AAMSE Advisory Committee to James Sammons, M.D., EVP of the AMA. The seminar provided an indepth review of the health system and involved physicians, hospital administrators, medical school leaders and government personnel. As the week unfolded, it became apparent

that the national health care system in Canada has not solved the health care issue in that country.

Respectfully submitted,
KENNETH E. NEFF,
Executive Director

1978 MEMBERSHIP

(As of 9/8/78)

Active:		
AMA Members	942	
Non-AMA Members	<u>411</u>	1353
Life Members		<u>171</u>
TOTAL MEMBERS		1524
Less Deceased Members		<u>8</u>
		1516

Student Members:

Nebraska	64
Creighton	<u>30</u>
TOTAL	94

House Officer Members:

Nebraska	21
Creighton	6
Miscellaneous	<u>4</u>
TOTAL	31

	Omaha	Lincoln	Out-State	Totals
Private Practice	547	225	592	1364
Full-Time V.A.	16	12	10	38
Full-Time Emergency				
Room	20	9		29
Full-Time Dept.				
Public Inst.		7	9	16
Full Time Administration	5	7	1	13
Full-Time Medical School				
Faculty	245			245
Retired, Disabled,				
Not in Practice	<u>34</u>	<u>19</u>	<u>61</u>	<u>114</u>
TOTAL PHYSICIANS	867	279	673	1819
Total Members				1516
Total Non-Members				303

REPORT OF THE EDITOR, NEBRASKA MEDICAL JOURNAL

Volume LXII of the Nebraska Medical Journal was published in 1977. It contained 74 original articles, so that the average number of scientific articles published in each monthly issue was a little more than six; these were written by 83 different authors.

There were 56 editorials.

The Nebraska Medical Journal won First Prize in the Sandoz competition open to all fifty states last year. Because of our having won First Prize then, we are not eligible to enter the contest now, but we will do it again next year.

We continue to print Washington Notes, Down Memory Lane, Medicinews, Our Medical Schools, Welcome New Members, the President's Page, the Auxiliary, In

Memoriam, Fifty-Year Reminiscences, The Letter Box, Picture Gallery, Books, Between Cases, Coming Meetings, and State and National Organizations.

Reports of Committees, Councilors, and Delegates are published every six months in the Journal. Advertising seems better.

Your Editor received the Distinguished Service to Medicine Award at the graduating exercises of the University of Nebraska Medical Center, in Omaha, on May 21, 1978, and believes that being Editor of the Journal helped in the bestowing-of-the-Award decision, and that it was therefore an expression of the selection committee's belief in the excellence of the Journal.

It was a fine year for the Journal.

Respectfully submitted,
FRANK COLE, M.D.,
Editor

REPORT OF THE CREIGHTON UNIVERSITY SCHOOL OF MEDICINE

Recalling a shop-worn phrase, "it seems like only yesterday . . ." that I prepared the report of the Creighton University School of Medicine for the 1978 Annual Session of the House of Delegates. Still, in the four brief months that have intervened since that session, and the preparation of this report, we have graduated 111 new physicians, and launched the class of 1982. The "cycle" has been completed and begun once again.

Perhaps a brief profile of our new freshmen would be of interest to the group. Twenty states of residence are represented by the 110 students, including 28 from Nebraska. Wyoming has provided 20 of our new students, and Iowa and California 12 each. Eighty-five of the new freshmen are from the area of the country including the Mid-west to the Rocky Mountains. Consistent with our policy to advance our mission by emphasizing acceptance of students from our own undergraduate professional program, more than half of the new class members had their premedical training at Creighton. The remainder represent 30 separate colleges and universities located throughout the United States. Eighteen of the 110 freshmen are women, and nine are members of the ethnic minority groups as defined by the Department of Health Education and Welfare. In addition to these 110 physicians-to-be, the regular junior class has been supplemented by the admission with advanced standing of nine American citizens who have taken their basic science work at another American or foreign university, bringing the total number of members in that class to 115 in accordance with the legislative requirements of the Congress for the 1978-79 academic year.

The months spanning the end of one academic year and the beginning of another are traditionally those during which most faculty changes occur. Our faculty has been joined by 21 new members since the first of May, representing one or more new members each in the departments of pathology, medicine, family practice, pediatrics, microbiology, preventive medicine and public health, surgery, and radiology. While some of the new members of the faculty are filling positions vacated by individuals who have terminated, for the most part the additions represent our continuing effort to improve our program offerings through modest and rigorously controlled growth of the faculty. I am very pleased with the qualifications of our new faculty members and

believe it to have been — in the parlance of our more athletically inclined colleagues — a “good recruiting year.”

In the recruitment arena, the period between academic years offered no opportunity for respite on the part of search committees for departmental chairmen. Search committees are currently in varying stages of progress in the filling of vacancies in several academic departments. While the number of existing vacancies is larger than usual, I in no way view this as reason for alarm.

While financing of a growing program with increasing demands is always a source of concern to us, there have been no unusual developments during the period of this report. Capitation awards are likely to remain stable for at least this next year, with the prospects beyond that time being somewhat uncertain. As a consequence, we have been generally able to hold the line on tuition increases for the current year at well below 10% which leaves our tuition for entering students well below the mid point for all private medical schools in the country. Abandonment by the federal government of any financial responsibility for direct program support in the future will likely change that picture substantially.

Two issues relating to governmental relationships with medical education have attracted considerable interest in the last few months. The first of these is the celebrated “Bakke case” decision handed down by the Supreme Court of the United States. Since most of you have undoubtedly read about all there is to read on the Bakke case, it will probably be sufficient to point out that we foresee no effect of that decision on our own admissions program. Since the effect of that decision was to cite quota systems for selection of students to study medicine as illegal; and since we have not operated under any kind of quota system, our program will not likely be forced to change. For those of you interested, a summary of our admissions program has been submitted for early publication in the NEBRASKA MEDICAL JOURNAL.

Another issue still far from resolved centers upon the so called “Section 227” provision of Medicare/Medicaid legislation. The Department of Health Education and Welfare is currently in the process of developing regulations governing this complex legislation and likely will begin their implementation very soon. The draft regulations that currently exist, if implemented, will work a severe hardship on medical schools by establishing an extremely unfavorable basis for reimbursement under Medicare/Medicaid laws. The net effect may very well be one of discouraging physicians from joining medical faculties and practicing in teaching hospitals. I invite careful consideration by the members of the Nebraska Medical Association of the issues surrounding this significant piece of health legislation.

As most of you know, this is Creighton University's Centennial Year. The climax of the University's observance of its 100th birthday will be the inauguration of a new president in something less than a month. Worthy of speculation in terms of its significance is the fact that the new president destined to guide Creighton University into its second century is the Reverend Matthew E. Creighton, S.J. For those inclined to be alert to omens, this must be a good sign!

Respectfully submitted,
JOSEPH M. HOLTHAUS, M.D.
Dean

REPORT OF THE UNIVERSITY OF NEBRASKA MEDICAL CENTER

I again welcome the opportunity to discuss the state of the Medical Center with the House of Delegates of the Nebraska Medical Association. Overall we have had a good year and anticipate significant developments in the months ahead.

Of most interest perhaps is the selection of a Dean of the College of Medicine. As I write these words it appears that the selection process is in its final stages and may be completed by the time of your meeting. Our Dean Search Committee has done its work efficiently, presenting me with its recommendations after a thorough screening of more than one hundred candidates. The individuals recommended have distinguished records and appear to have the talent to get the job done. The presence on the committee of three private practitioners — Drs. Charles McLaughlin, Jerald Schenken and Richard Tollefson — gave the selection process a breadth it could not have had otherwise.

I would like also to commend Dr. Miles Skultety for the exceptional job he is doing as Interim Dean. The College of Medicine has not stood still during the time he has been in office.

Financially, the Medical Center is solvent, but the situation is tight enough to prevent us from beginning major new programs or expanding existing ones. The University is submitting a 1979-80 state budget request which is about six percent above the current year excluding salaries. As President Roskens has described it, this is the second year in a row in which the budget request is “lean.” This year, for example, our share of state dollars was about three percent higher than the previous year.

The Medical Center was able to generate increased funds from tuition and patient care sources. While there will be no new state-funded buildings at the Medical Center, we will in the coming year be able to improve the Hospital's ability to serve as a tertiary center for the state. Later this fall we will begin remodeling a neonatal nursery, in order to achieve a more efficient environment to properly take care of an increased number of patients. We also have on order a linear accelerator to replace the obsolete betatron now used in radiation therapy.

The College of Medicine did receive federal capitation funds this year, but signals from Washington continue to alert us that this program for supporting medical education may be short-lived.

I can report positive steps toward addressing the health manpower problems of non-metropolitan areas of the state. The Legislature last session passed LB 884, the student loan forgiveness program, under which loans to finance medical education can be written off in return for service in rural or urban shortage areas. In the legislative process, however, the original bill was broadened to make students attending schools outside of Nebraska eligible for loans. On that point the Attorney General's office opined that the law was unconstitutional. We will be working with the Governor's Rural Health Commission to make the necessary amendments to the bill in the next session of the Legislature.

We have added a rural physician to our Admission Committee, a recommendation which the House of Delegates made last year and a suggestion we believe is thoroughly sound.

Another effort in the area of rural health has been made possible through the generous support of the W. K. Kellogg Foundation. Under this grant the College of Medicine will attempt to develop rotations in rural Nebraska for primary care residents and will explore the feasibility of developing a family practice residency in the Kearney - Grand Island - Hastings area.

On another topic, the conversion to a four-year curriculum in the College of Medicine began with the freshman class this July. Because of the phasing of this change as well as the acceptance of transfer students, we will not experience a year without a graduation; in fact each year's graduates should be in sufficient numbers to staff house officer training programs at a fairly consistent level.

Finally, I believe the Medical Center is entering a new era which presents a new set of challenges. Growth in enrollment, which has been almost the dominant characteristic of the Medical Center for the past decade, is for the most part over. Funds will continue to be limited. Our challenge in the years ahead will not be so much to grow bigger as it will be to improve the quality of what we do. With your help I am confident this goal can be accomplished in spite of the restricted resources which will be available to us.

Respectfully submitted,
NEAL A. VANSELOW, M.D.,
Chancellor

REPORT OF THE COMMISSION ON ASSOCIATION AFFAIRS

Dwaine J. Peetz, M.D., Neligh, Chairman; R. L. Cassel, M.D., Omaha; Louis J. Gogela, M.D., Lincoln; Clyde L. Kleager, M.D., Hastings; J. P. Schlichtemier, M.D., Omaha; Joseph C. Scott, M.D., Omaha; Stephen Woodman, M.D., Grand Island.

(1) The Commission on Association Affairs met on Wednesday, July 19, 1978, at the Country Club in Lincoln. During this meeting, this Commission reviewed the various responsibilities assigned to it and proceeded accordingly.

Our first responsibility had to do with insurance contracts, and at this time there was no action needed in this area.

Modification of the Articles and By-Laws was discussed, and in conjunction with this the Commission discussed the House action requesting review of the current Councilor Districts and dual references to house officers. This matter was referred to an ad hoc committee consisting of Dr. J. P. Schlichtemier of Omaha, as Chairman, Dr. R. L. Cassel of Omaha, Dr. Clyde Kleager of Hastings. The recommendations of the ad hoc committee are contained elsewhere in this report.

A resolution from the Holt and Northwest County Medical Society dealing with admission procedures for students at the University of Nebraska Medical Center was reviewed. Dr. Peetz has been aware of many of these problems, as he also serves on the Governor's Rural Health Commission. It was the general feeling of the Commission on Association Affairs that the Medical Association did not have the prerogative to tell the Medical Center what its admission procedures should be. We did wish to inform, however, the Medical Center of this request and of our action.

A discussion of the Medicare regulations concerning the limitations of reimbursements to physicians for laboratory services followed, and our Commission selected Dr. Jerald R. Schenken, Dr. C. Lee Retelsdorf, and Dr. R. F. Sievers to an ad hoc committee to work on this particular problem.

Membership activities of medical students and house officers were discussed. Dr. Hayes indicated that there are several house officers in the Family Practice Clinic in Lincoln who do not come from either of the two medical schools in Omaha. He suggested letters of invitation to join house officer organizations should be extended to these Lincoln residents.

Mrs. Harry D. Shaffer, President of the NMA Auxiliary, then gave a report. She discussed the National Auxiliary and indicated several states will stress health education, immunization, and CPR to their local auxiliaries. She reported that the Nebraska Medical Association Auxiliary currently has membership of 800 members, and also that Mrs. Leland J. Olson is now on the National Board of Directors. She announced Mrs. Robert F. Lovgren is the State Legislative Chairman, Mrs. Robert H. McIntire of Hastings will be the Auxiliary representative on Nebraska MEDPAC, and she further requested names of members available for other assignments such as health education. These nominees will be forwarded to the NMA headquarters office so that the Association's Commission and the respective ad hoc committees may utilize them.

Other items discussed by the Auxiliary were the activities in the Nebraska Medical Foundation, and hopefully in the future the Auxiliary will place greater emphasis on the Nebraska Medical Foundation program.

A final item had to do with the students' wives project. Mrs. Shaffer requests that the wives of medical students be given opportunities, along with their husbands, to spend weekends in the rural committees. The Auxiliary, however, will not pursue this program, and the Commission will take this under advisement.

As a final matter, the Chairman of this Commission indicated his desire that the meetings of this Commission and all other state medical meetings be scheduled at a time suitable to all members, and that the meetings begin on the appointed hour.

(2) AD-HOC COMMITTEE ON ARTICLES AND BY-LAWS

An ad-hoc committee considered several matters referred to this Commission by the House of Delegates at its May, 1978 session.

Concern had been expressed by a Reference Committee at the Annual Session about the overlapping of component county medical societies into two Councilor Districts. Our ad-hoc committee reviewed the areas in which this situation occurs and decided a mechanism exists in the NMA By-Laws should a component county medical society desire a transfer from one Councilor District to another. A letter and an accompanying map (showing the individual counties and each Councilor District) was sent the secretary of each component county medical society reminding them of the wording in the By-Laws (page 24, Chapter VII, Section 9) which states that, "Upon petition by two-thirds of the members in any county, the House of Delegates may transfer that county from one Councilor District to another." We feel this mechanism should resolve current areas of concern, as well as those which might develop in the future.

The ad-hoc committee was also asked to address the confusion which might develop about possible dual representation between house staff component societies and component county medical societies. Association legal counsel was asked to consider this matter, and we present the following proposal for consideration by the House, which will resolve future questions regarding this subject: Amend the second sentence of Section 1, Chapter VI, beginning on Page 16 of the NMA By-Laws to read as follows: "Each component society, or group of societies so organized, in good standing having five or more members of the component society (other than house officers) in the Nebraska Medical Association shall be entitled to send to the House of Delegates each year one delegate for the first five active members (other than house officers) who are in good standing on December 31 of the calendar year immediately preceding."

The ad-hoc committee also considered the matter of assigning the responsibility for the subject of federal legislation and regulations to the Commission on Governmental Affairs. This matter is currently the responsibility of the Commission on Legislation and Legal Affairs. There are several reasons for the transfer of this responsibility to the Commission on Governmental Affairs. The primary reason is the Commission on Governmental Affairs deals more closely with federal level rules, regulations, etc., which affect the Association. We recommend the following wording be added to the responsibilities of the Commission on Governmental Affairs (Page 46, Chapter XIII, Section 2C) as Item (4): "Consider matters of a legislative and regulative nature at the federal level which would affect the practice of medicine." And that the responsibilities of the Commission on Legislation and Legal Affairs be modified to read (Page 46, Chapter XIII, Section 2D): "(1) Consider matters of a legislative and regulative nature at the state level which would affect the practice of medicine." These amendments to the By-Laws will need to be considered for final adoption at the 1979 Annual Session, however the intent of this change of responsibility is already being implemented by both Commissions.

Respectfully submitted,
DWAINE J. PEETZ, M.D.
Chairman

REPORT OF THE COMMISSION ON GOVERNMENTAL AFFAIRS

C. J. Cornelius, Jr., M.D., Sidney, Chairman; John D. Coe, M.D., Omaha; John F. Porterfield, M.D., Lincoln; Donald F. Prince, M.D., Minden; Harold M. Nordlund, M.D., York; Jerald R. Schenken, M.D., Omaha; Thomas H. Wallace, M.D., Gordon.

Your Commission on Governmental Affairs has attempted to carry out the functions of the former Health Planning Committee, of the Committee on Federal Legislation, and several others and is just beginning to appreciate the scope of its charge.

STATE HEALTH PLAN: We have attempted to develop a working knowledge and understanding of the Preliminary State Health Plan which was released for review by the State Health Coordinating Council on June 30, 1978, and became available on July 15, 1978. On July 24th, your commission met via telephone conference to plan for review of this document and assign responsibilities for representing the NMA at a two-day Implementer Conference convened in Lincoln

by the SHPDA (State Health Planning & Development Agency) for receiving input from interested parties via the workshop format. Members of the commission and several additional volunteers (draftees) caucused with the chairman via telephone on the eve of this conference to discuss strategy and tactics for this conference and then participated in same. The NMA was well represented on both days of the conference and a summary of the discussions and conclusions will be provided to the Systems Planning Committee and to the SHCC (State Health Coordinating Council) for their review prior to final action on the State Health Plan currently scheduled for September 22nd.

A line, chapter, and verse review of this preliminary State Health Plan was not attempted by your commission due to time constraints but rather appropriate items were addressed as adequately as possible by the NMA workshop participants and a statement based mostly on the philosophical approach to health planning was presented at the Public Hearing on the Preliminary State Health Plan by NMA President, Dr. Steenburg, on August 17th. A copy of this statement is appended. The NMA position on many of the items covered in the plan has been and will continue to be well represented since your Commission Chairman is also Chairman of the Systems Planning Committee of the SHCC, the committee responsible for continuing development and review of this document, (the committee which will review all the workshop summaries and all the testimony received at the public hearing and respond to each and every comment and revise the document as indicated and present the revised plan to the entire SHCC for its approval). Any comments that members of the Association may have regarding the State Health Plan should be forwarded to this Commission via the State Medical office so that we may continue to monitor developments and plan for future participation in the planning process. The State Health Plan as well as the Health Systems Plans of each of the HSA's are to be revised annually and the second generation documents are already beginning to take shape. At the time of this writing the process of setting up "watch dog" committees to monitor the activities of the HSA's and the SHCC is incomplete but a list of volunteers is being compiled. If you wish to volunteer for this service please indicate your willingness to the Chairman of the Commission, one of the NMA officers, or to the headquarters office. Keep those cards and letters coming in.

MEDICARE REIMBURSEMENT FOR LABORATORIES: Your Commission also discussed HCFA's rule #628 during the telephone conference of July 24th, and President Steenburg has since appointed a committee made up of Drs. Sievers, Schenken, and Retelsdorf to meet with Mr. Jim O'Brien of Mutual of Omaha regarding this issue. This is the rule which limits physicians to a \$3.00 reimbursement for collecting laboratory specimens for transmittal to a consulting laboratory for processing regardless of the simplicity or complexity of specimen collection, handling, etc. Members of the Nebraska Congressional Delegation have been made aware of the problem this rule creates and have done some preliminary work on it. However, we are awaiting the results of the above mentioned meeting before proceeding further on this issue.

OTHER: This Commission is prepared to continue activities with regard to Federal Legislation if it is the will of the House that it do so. Some confusion presently exists as to the scope of the Commission's charge regarding this matter.

We wish to thank Drs. Fuenning, Bosley, Stein, Graves and Retelsdorf and Mr. Neff and Mr. Schellpeper for their participation in the Implementers Conference on the State Health Plan, August 15th and 16th.

For the information of the House, a copy of the Carter Administration "Principles for a National Health Plan" and a copy of the AMA's Summary for HR1818 and S218 are appended to this report.

Respectfully submitted,
C. J. CORNELIUS, JR., M.D.
Chairman

NEBRASKA STATE HEALTH PLAN **Comments submitted by the Nebraska** **Medical Association**

The State Health Plan is a very complex and comprehensive document which obviously is the result of many hours of exhaustive research and thoughtful consideration. It is evident on reading the plan that a number of assumptions have been set forth both from the writings of authors quoted in the text, in guidelines that have been promulgated by HEW, and in PL 93-641 itself. Several of these assumptions are as follows:

1. Providers, both individual and institutional, tend to create demand for their services.
2. Consolidation of services reduces the unit cost per service because of the increased volume and is likely to provide better service because of a concomitant improvement in expertise.
3. A reduction in acute care beds will result in lower medical care expenditures.
4. The Public will take advantage of increased opportunities for health education, etc.

These are but a few of the many assumptions that need to be analyzed critically and tested specifically before any large scale plans or programs are put into effect which would alter the health care system in Nebraska. It is well to remember that "progress frequently requires change but change is not necessarily progress."

Critical analysis of new strategies, procedures, modalities, and medications are a way of life in our profession but is not fundamentally appreciated in many other vocations and professions. The scientific approach to problem solving starts with an understanding of the problem, its magnitude, importance, ramifications, prevalence, and effects. Next the possible solutions to that problem are considered. Then an experimental model, feasibility study, or "controlled" field trial is designed, implemented, and the results analyzed; and only then, if the study confirms the desired outcome, is a larger project or program devised. Needless to say, the results of the clinical trial must also indicate that the program will be cost effective.

If each and every one of the assumptions set forth in this State Health Plan is subjected to this type of critical analysis then change will indeed result in progress. It is considered important to again stress the grass-roots orientation of PL 93-641 and to encourage the SHCC to remain steadfast in its dedication to this principle. Historically, programs of this type have tended to become vehicles for social change devised and disseminated from Washington by persons who have no concept of what true "Rural America" even looks like let alone understand its problems. We would like to suggest that worthwhile changes in the health care

field will sell themselves to Nebraska citizens and won't require an act of Congress or of the Unicameral.

We would like to leave you with one last thought: "That government has never succeeded in providing comparable services to its citizens at less cost than the private sector." One has only to look at the record of military, public health, V.A., and state hospitals for confirmation. Government has only been able to reduce costs to beneficiaries of government financed health care by shifting part of the cost of such care to the private sector. Should government become the sole source of financing in the health care field, there will cease to exist any opportunities for cost shifting, and cost containment will be possible only through penalizing the persons who work in the health care field, as was done several years ago with the wage and price freeze, and/or by rationing services to the beneficiaries. Other National models of government health care systems have demonstrated that it is the persons in the rural areas that are the hardest hit by these strategies — Nebraska if you will.

The Nebraska Medical Association looks forward to cooperating with the SHCC and the SHPDA in planning for improvement of the health of Nebraska citizens. The Association's Commission on Governmental Affairs has been assigned the primary responsibility for monitoring the progress of the State's efforts under PL 93-641 and will respond to questions or requests that you might have. We appreciate the opportunity to comment on this first draft of the State Health Plan.

A BRIEF SUMMARY OF THE AMA NATIONAL **HEALTH INSURANCE PROPOSAL** **H.R. 1818; S. 218, "Comprehensive Health Care** **Insurance Act of 1977"**

The AMA program would make comprehensive private health insurance available to all persons, regardless of income. The benefits are comprehensively broad, covering full hospital care, full physician care (wherever provided, both in and out of the hospital), home health services, emergency care, lab and x-ray services, extended care services, etc. It would provide both **basic** and **catastrophic** coverage for costs of illness. The range of benefits embrace preventive, diagnostic and therapeutic services.

This protection would come through private health insurance. Most persons would receive this insurance through their employment. Their employers would be required to offer the full-benefit coverage to their employees and their families, and pay at least 65% of the premium — and many employers would no doubt continue the practice of paying more. The employee would pay any difference.

Low-income or unemployed persons would obtain the same full coverage from their own insurance companies, and the government would contribute toward the premium. The government would pay all of the insurance premium for the poor, and gradually less for others on a scale related to their incomes. As income increased, the federal assistance would diminish.

Elderly individuals would also be able to obtain private insurance to build up the level of their Medicare benefits to the level of the full benefits program, and the government would pay for all or part of such insurance depending on the individual incomes.

There would be some coinsurance, to keep costs of the program down, except that the poor would pay nothing. Any coinsurance that an individual or family would have to pay in any year would be limited in relation to

their income, but even this would be further limited by a fixed amount applicable to all persons. The limit on the amount any individual or family would have to pay in any year would assure against any economic hardships because of costly illness. There would be no deductible; benefits would begin immediately.

No special taxes would be needed to finance the program. Financial participation of the government would be very limited, and would come primarily as payment of premium for the poor and premium assistance for individuals or families with low incomes. As is true today, most of the premium for comprehensive health insurance protection would come from employee group insurance, and employers would pay the major part of that premium. Subsidies would be available to assist employers experiencing substantially increased costs.

Adoption of this program would assure continuation of the advantages of our system of health care and the quality of such care. The individual would choose his physician and the method under which he would receive his health care, and his insurance would provide him the full protection — both basic and catastrophic — he needs against the costs of illness.

PRESIDENT CARTER'S PRINCIPLES FOR A NATIONAL HEALTH PLAN

1. The plan should assure that all Americans have comprehensive health care coverage, including protection against catastrophic medical expenses.
2. The plan should make quality health care available to all Americans. It should seek to eliminate those aspects of the current health system that often cause the poor to receive substandard care.
3. The plan should assure that all Americans have freedom of choice in the selection of physicians, hospitals, and health delivery systems.
4. The plan must support our efforts to control inflation in the economy by reducing unnecessary health care spending. The plan should include aggressive cost containment measures and should also strengthen competitive forces in the health care sector.
5. The plan should be designed so that additional public and private expenditures for improved health benefits and coverage will be substantially offset by savings from greater efficiency in the health care system.
6. The plan will involve no additional federal spending until FY 1983, because of tight fiscal constraints and the need for careful planning and implementation. Thereafter, the plan should be phased in gradually. As the plan moves from phase to phase, consideration should be given to such factors as the economic and administrative experience under prior phases. The experience of other government programs, in which expenditures far exceeded initial projections, must not be repeated.
7. The plan should be financed through multiple sources, including government funding and contributions from employers and employees. Careful consideration should be given to the other demands on government budgets, the existing tax burdens on the American people, and the ability of many consumers to share an appropriate portion of the cost of their care.

8. The plan should include a significant role for the private insurance industry, with appropriate government regulation.
9. The plan should provide resources and develop payment methods to promote such major reforms in delivering health care services as substantially increasing the availability of ambulatory and preventive services, attracting personnel to underserved rural and urban areas, and encouraging the use of prepaid health plans.
10. The plan should assure consumer representation throughout its operation.

REPORT OF THE COMMISSION ON LEGISLATION AND LEGAL AFFAIRS

Herbert E. Reese, M.D., Lincoln, Chairman; John H. Bancroft, M.D., Kearney; James H. Dunlap, M.D., Norfolk; Blaine Y. Roffman, M.D., Omaha; Robert F. Shapiro, M.D., Lincoln; A. L. Smith, Jr., M.D., Lincoln; R. L. Tollefson, M.D., Wausa; Stanley M. Truhlsen, M.D., Omaha.

The Commission on Legislation and Legal Affairs had an organizational meeting on Wednesday, July 12, 1978 at the Nebraska Medical Association headquarters office in Lincoln, Nebraska. The responsibilities of this commission were discussed as noted in the by-laws of the Nebraska Medical Association.

Proposed legislation was reviewed and the following legislation will undoubtedly be back in the next legislative session:

- 1) LB 595 This legislative proposal will alter the Nebraska law to allow optometrists to use eye drugs.
- 2) LB 669 Increase the number of students in the Physician's Assistant Program at the University of Nebraska Medical Center.
- 3) LB 740 Register school psychologists.
- 4) LB 778 Authorize manufacture and sale of Laetrile.
- 5) LB 795 Provide for filing certificate of need for health care facilities.
- 6) LB 844 Allows additional credentials for medical practice.

Proposed rules and regulations in legislation concerning PKU, hypothyroidism and Rh disease were discussed at length. This proposed legislation will be reviewed by the committee and Dr. Robert Grant has been asked to meet with the commission in the latter part of August for review of this proposed legislation.

Jim Dunlap was selected as chairman of the subcommittee for medical legal advice. The physician contacts with Legislators was reviewed and this will have to be revised after the coming election.

There is a real trend across the nation for medicine by legislation. Nebraska is no exception. It would appear this commission will be an active commission now and in the years to come. The commission will also need active support of Nebraska Medical Association members in order to accomplish its goals.

Respectfully submitted,
HERBERT E. REESE, M.D.
Chairman

REPORT OF THE COMMISSION ON PUBLIC AFFAIRS

C. Lee Retelsdorf, M.D., Omaha, Chairman; Leonard J. Chadek, M.D., West Point; Donald Matthews, M.D., Lincoln; Karl F. Niehaus, M.D., Omaha; Craig R. Nolte, M.D., Lincoln; John W. Porter, M.D., Beatrice; Hiram R. Walker, M.D., Kearney.

The Commission has reviewed Resolution Nine from the last meeting of the House of Delegates relating to "health education of patients." They have also reviewed the action taken by the Commission on Medical Education and concur with their recommendations.

"HEALTH TIPS:" Health tips continue to be available for members as inserts in their patient billings. It is noted that the NMA is producing approximately 20,000 inserts per month (1,600 are sent out with the NMA's newsletter and one clinic uses 10,000 per month). The Commission feels that after reviewing the patient response to these Health Tips that a better marketing effort should be undertaken. A letter with four available inserts has been sent each Association member. In the near future, a letter will be sent the president of each county medical society explaining the program and asking his cooperation in encouraging physicians to use these Health Tips. We are recommending that county medical societies announce the availability of these inserts at their meetings.

The Commission is investigating the possibility and the feasibility of developing a series of short items on socioeconomic issues that could utilize the same format as the Health Tips to be made available for physicians inserts in their patient billings.

The NMA is continuing to send to all types of news media in the State of Nebraska on a monthly basis health information items suitable for the media's use. Overall, there has been a good utilization by the media of these Health Tips.

In December of 1978, there will be sent to all the radio stations short recorded items by the president of the NMA for their use.

"VOLUNTARY EFFORT:" The Commission has been assigned the responsibility for the Voluntary Effort. Members of the Commission have held an exploratory and informational meeting with representatives of the Nebraska Hospital Association Ad-Hoc Cost Containment Committee. Following this meeting it was the joint decision of the two associations to form a joint committee. Dr. Harold Nordlund, Dr. Craig Nolte and Dr. Retelsdorf, at the request of President Steenburg, are serving as the NMA representatives to this committee. One meeting of the joint committee has been held. This meeting was an organizational meeting only.

Respectfully submitted,
C. LEE RETELSDORF, M.D.
Chairman

REPORT OF THE COMMISSION ON CLINICAL MEDICINE

Robert M. Stryker, M.D., Omaha, Chairman; Allen J. Alderman, M.D., Chadron; Patrick E. Clare, M.D., Lincoln; John C. Goldner, M.D., Omaha; Joel T. Johnson, M.D., Kearney; Robert G. Osborne, M.D., Lincoln; William L. Rumbolz, M.D., Omaha; Richard B. Svehla, M.D., Omaha.

Scientific Sessions Committee: Robert M. Stryker, M.D., Omaha, Chairman; Richard A. Hranac, M.D., Kearney, Meeting Chairman; Richard A. Cottingham, M.D., McCook; Joel T. Johnson, M.D., Kearney; David L. Kutsch, M.D., Lincoln; James E. Brown, M.D., Omaha; Y. Scott Moore, M.D., Lincoln; James M. Steier, M.D., Omaha.

Pursuant to the revised By-Laws of the Nebraska

Medical Association, approved in May, 1978, this Commission was established and charged with the following responsibilities:

- a. The creation of a permanent Scientific Sessions Committee
- b. School athletic program
- c. Matters and information relative to cancer
- d. Emergency medical service planning and operation
- e. Geriatrics
- f. Maternal and child health
- g. Mental health
- h. Public and occupational health
- i. Cardiovascular problems
- j. All other health problems the Commission deems appropriate

This Commission met on June 15, 1978, and recommended to the President of the NMA the following:

- a. Establish an ad-hoc committee on Maternal and Child Health
- b. Establish an ad-hoc committee on Emergency Medical Services
- c. Establish an ad-hoc committee on Athletic Medicine

The President concurred and these ad-hoc committees were established. Brief reports from these committees follows.

REPORT OF THE AD-HOC COMMITTEE ON MATERNAL AND CHILD HEALTH: Chairman, Dr. William Rumbolz. This committee is divided into two sections: Section on Maternal Mortality Review, Drs. Charles Field and Rumbolz; and Section on Perinatal Mortality Review, Drs. John Goldkrand, Glenn Haswell, Ken Shaffer, Rumbolz, and Robert Grant (Ex-officio, Head of Division of Maternal and Child Health, State Health Department).

This committee has not as yet formally met, but will continue to monitor and report on maternal deaths. The main effort of this committee will be to implement the Perinatal Mortality Questionnaire.

REPORT OF THE AD-HOC COMMITTEE ON EMERGENCY MEDICAL SERVICES: Chairman, Dr. Richard Svehla. Members: Drs. Stephen Carveth, Kenneth F. Kimball, and Dean A. McGee. This committee is meeting this month. Prior to the spring meeting, it is anticipated this committee will address itself to, and hopefully make specific recommendations, regarding the following:

1. The teaching of the public and recruitment of the public's participation in programs concerning cardiopulmonary resuscitation.
2. The development of better rapid transport systems for critically ill patients especially in rural areas.
3. The establishment of a line of communication among the State Health Department, the various emergency medical systems councils and the Nebraska Medical Association.
4. The expansion of emergency medical care communications systems.
5. The notification of hospitals and their related medical staffs of an emergency room categorization and classification system.

REPORT OF THE AD-HOC COMMITTEE ON ATHLETIC MEDICINE: This committee is busy planning for the Nebraska High School Team Physician's Seminar, to be held on Saturday, October 28. The topics for this year's meeting are Nutrition, Strength-Building and Management of Acute Injuries in Athletics.

REPORT OF THE SCIENTIFIC SESSIONS COMMITTEE: Chairman, Dr. Robert M. Stryker, Convention Chairmen, Dr. Richard A. Hranac, Members: Drs. James R. Brown, Richard A. Cottingham, Joel T. Johnson, David L. Kutsch, Y. Scott Moore, and James M. Steier.

Annual Scientific Session — Plans are being finalized for the 1979 Annual Meeting in Kearney. Geriatrics and Adolescent Medicine will be emphasized.

Exhibits — This committee has been analyzing this subject for over a year. The following observations have been drawn:

1. There has been an increasing lack of physician interest in the exhibits.
2. Costs for space, decorating, etc. have steadily been increasing.
3. Considerable NMA Headquarters administrative/secretarial time is necessary in obtaining exhibitors.
4. Currently, the NMA has more non-medical than medical exhibitors.
5. Meeting facilities are limited because of the space needed for exhibitors.

The NMA Headquarters Office has sent letters to various State Medical Associations who have discontinued the practice of having exhibits at their annual meetings. Most associations stated the reason they had eliminated exhibits was due to the lack of physician interest in exhibits and increasing costs. Most associations were not interested in reinstituting exhibits. Approximately 17 states have discontinued exhibits. Most states who have discontinued exhibits have solicited grants from these companies instead.

This committee recommended to the Commission on Clinical Medicine that exhibits at the Annual Scientific Session be discontinued, and that grants be solicited from the companies.

Registration Fee — This committee evaluated the pros and cons of charging a registration fee for physicians attending the Annual Scientific Meeting. It was noted that there are very few scientific meetings where there is no fee charged. A registration fee would help to off-set loss of income from exhibitors.

This committee recommended to the Commission on Clinical Medicine that a registration fee be charged for the Annual Scientific Meeting.

AMA Category I CME Credit — Co-sponsorship of scientific presentations and the awarding of Category I credit, is part of the responsibility of this committee. Although this committee has co-sponsored several presentations, it is felt that more organizations, hospitals, etc. could qualify for this credit. The criteria for co-sponsorship is specific and must be allowed.

GUIDELINES FOR THE ISSUANCE OF AMA CATEGORY I CREDIT

1. The proposed activity must be sponsored/co-sponsored by the Scientific Sessions Committee of the Nebraska Medical Association.
2. Approval must be secured from the Scientific Sessions Committee prior to any publicity about the activity and prior to the beginning of the activity. A joint planning meeting and direct involvement of the Scientific Sessions Committee in the program is required.
3. The activity is planned in response to an assessment of educational need for activities prepared prior to the beginning of that activity.

4. There is a written statement of objectives, rationale and purpose for such activities prepared prior to the beginning of that activity.
5. Content is selected and organized in a sequential manner.
6. The faculty selected for the teaching must be competent for the subjects to be presented.
7. The curriculum must be of suitable breadth and depth to achieve the objectives stated.
8. Suitable educational methods must be utilized to accomplish the stated objectives.
9. The program consists of not less than 1 instructional hour.
10. Evaluation procedures must be determined during the planning process to be used to measure the effectiveness of the program design and operation.
11. Specific requirements for the award of Category I credit must be established prior to the offering of the learning experience.
12. Registration procedures must be such that a permanent record can be maintained for each participant by the Nebraska Medical Association.
13. Results of evaluation procedures are to be provided the Scientific Sessions Committee following the activity.

This committee recommended to the Commission on Clinical Medicine that the members of the NMA again be made aware that co-sponsorship is available, and that the Criteria for AMA Category I CME credit be distributed to the members.

RECOMMENDATION: The Commission recommends that the Criteria for AMA Category I CME credit be distributed to the members of the NMA and that institutions, county medical societies, etc. be encouraged to request co-sponsorship of scientific presentations.

Recommendations of this Commission to the Board of Directors of the NMA:

1. Non-scientific exhibits should be discontinued at the Annual Scientific Meeting.
2. Grants should be solicited from those who exhibited.
3. A registration fee should be instituted for those attending the Annual Scientific Meeting.

This Commission felt no other ad-hoc committees were necessary at this time. Members of this Commission will continue to monitor the activities of the State Department of Institutions rules and regulations for state hospitals.

Respectfully submitted,
ROBERT M. STRYKER, M.D.
Chairman

REPORT OF THE COMMISSION ON MEDICAL EDUCATION

John W. Smith, M.D., Omaha, Chairman; Warren G. Bosley, M.D., Grand Island; Wendell L. Fairbanks, M.D., Alliance; Michael J. Haller, M.D., Omaha; Robert D. Harry, M.D., Lexington; Leonard R. Lee, M.D., Lincoln; Robert J. Stein, M.D., Lincoln; Paul R. Young, M.D., Omaha

The Commission on Medical Education met on two occasions subsequent to the April session of the House of Delegates to consider matters referred to the Commission, as well as subject areas assigned this

Commission as a result of the new organizational structure of the Association.

An Ad-Hoc Committee on Health Education was appointed to consider this broad subject area and specifically those items referred to the Commission by the House of Delegates.

The Commission developed the following position statement regarding patient education: "The Nebraska Medical Association encourages patient education recognizing the individual physician and the hospital medical staff have the major responsibility for implementing and monitoring the informational process and materials used for each patient. The Association encourages its members to become involved and to assume the responsibility for patient education. Patient education must be done under the physician's direction."

A site survey team visited Lincoln on July 11, to consider the application for Category I accreditation status submitted by the Lincoln hospitals, the Lincoln Medical Education Foundation and the Lancaster County Medical Society. The team recommended provisional accreditation for two years. This recommendation was endorsed by the Commission on Medical Education and the Association Board of Directors. The recommendation has now been submitted to the Liaison Committee on Continuing Medical Education for final approval.

The Commission considered proposed guidelines submitted by the LCCME intended to clarify areas of accreditation terminology, the duration of accreditation and remedial suggestions regarding the mechanism of resurvey. It was felt the proposal would clarify several areas and assist the Commission in its efforts, consequently a letter supporting the changes was sent the LCCME.

The Association has again participated in the AMA mailing to Nebraska physicians recommending and encouraging members to participate in the AMA Physician's Recognition Award Program. Earlier this year, the NMA distributed a tabulation sheet and instruction/information booklet encouraging Association members to utilize the materials in recording the CME activities in which they take part.

AD-HOC COMMITTEE ON HEALTH EDUCATION:

The Ad-Hoc Committee on Health Education met on 17 August 1978. The Chairman first reviewed the history of this committee since its formation approximately 20 years ago. Initially, its responsibility was to develop liaison between the NMA and the State Board of Education, and to work in the field of health education. This liaison was formed with considerable difficulty and took several years to develop. The committee recognized that its first efforts should be devoted to the development of health education curricula in teachers' colleges, so that the sources would be available to carry out education in schools. This effort was met with only moderate success, but in 1971, legislation was passed which required that comprehensive health education shall be offered in all Nebraska schools, and that the Commissioner of Education must prepare, publish and distribute comprehensive health education guidelines. The committee, through the NMA, has tried for several years to encourage full implementation of this law, again with only moderate success to the present time.

The recently appointed health-physical education consultant for the Department of Education, Joanne

Owens, was present at this meeting and provided a review of the present activities of her division. She provided each member of the Ad-Hoc Committee a copy of the guidelines for health education in Nebraska schools as written for grades Kindergarten through Junior High school. She stated that there is still a shortage of qualified health educators and stressed again the need to continue efforts to develop suitable curricula in teachers' colleges. She emphasized the role that physicians can play in health education in their local schools. The committee recognized that it should urge the members of the Nebraska Medical Association to assume a more active role in prompting their local schools to build proper programs in health education. Guidelines are available and have been distributed by the State Department of Education. In addition, many schools have developed their own guidelines and detailed curricula, which might be available to schools wishing to do the same. Further information and help in doing this are available through the office of the NMA or the chairman of this committee.

The committee asked that the chairman try to arrange an appearance before the State Board of Education to express the concern of the committee regarding the current health education guidelines and to emphasize the interests of Nebraska physicians in cooperating in the development of these programs. The role of parent organizations was also stressed, and the committee recognized again the important role of the members of the auxiliary in bringing these matters to the attention of local boards of education.

The committee recognizes that often "health education" is interpreted as "sex education" and that there is an urgent need to make it clear that such is not the case, that health education programs should develop citizens who are well-informed about the importance of the maintenance of the best possible health.

Respectfully submitted,
JOHN W. SMITH, M.D.
Chairman

Report of Board of Councilors

The Fall Session of the Board of Councilors was held September 22, 1978, at the Hilton Hotel, Lincoln, Nebraska. The meeting was called to order by the Chairman, Dr. Wilson.

The following members were present: Drs. Carlyle E. Wilson, Myron E. Samuelson, James Carlson, Warren Miller, Richard Pitsch, Joel Johnson, Fred Rutt, Calvin Oba, Houtz Steenburg and Charles Landgraf, Jr.

Election of a Chairman was called for and Dr. Wilson was reelected as Chairman of the Board of Councilors.

Election of a Secretary was called for and Dr. James Carlson was elected as Secretary of the Board of Councilors.

The minutes of the Annual Session meeting were approved as printed in the July, 1978, issue of the Nebraska Medical Journal.

The reports and resolutions in the Handbook were reviewed by the Board of Councilors.

In reviewing the report of the Board of Directors, there was considerable discussion concerning Item #4, Second Opinion on Surgery. Dr. Miller moved that the Councilors support the position of the Board of

Directors and that the House affirm this action and remind the citizens of the state that physicians of Nebraska have always participated in second opinion on surgery and medicine. This was approved by the Councilors.

In reviewing Resolution #8, it was moved that the Councilors support this resolution and would in addition request that prior House of Delegates action regarding Blue Cross-Blue Shield relationship be supplied to members of the House. This was approved.

In reviewing Resolution #14, Dr. Carlson moved that only those specifically authorized by the patient should have access to records. This was approved.

The listing of Fifty-Year Practitioners and requests for Life Membership were approved by the Board of Councilors.

Each Councilor present was given a list of non-members within his District and was asked to contact these physicians urging them to become members of the Nebraska Medical Association and of the American Medical Association.

There being no further business, the meeting was adjourned.

Report of House of Delegates

FIRST SESSION

The first session of the Fall Meeting of the House of Delegates was held at the Hilton Hotel, Lincoln, Nebraska, September 23, 1978.

The meeting was called to order by the Speaker, Dr. McFadden. Roll call showed 69 delegates present, and the House was declared in session.

Dr. McFadden called for approval of the minutes of the Annual Session meetings of the House as printed in the July, 1978, issue of the Nebraska Medical Journal, and these were approved as printed.

Dr. McFadden read that portion of the By-Laws relating to the filling of vacancies and indicated that in accordance with this, the Board of Directors had selected Dr. Alvin A. Armstrong of Scottsbluff to fill the vacancy in the office of Vice Speaker of the House of Delegates. He asked suspension of the rules for approval of Dr. Armstrong, and this was approved unanimously.

Oral reports were presented to the House by Dr. Houtz Steenburg, President of the NMA and Dr. Neal Vanselow, Chancellor of the University of Nebraska Medical Center.

The following assignments were made to Reference Committees and approved by the House:

Reference Committee #1

- Report of the Delegate to the AMA
- Report of the Commission on Governmental Affairs
- Resolution #3 — Omaha Medical — Uniform IRS Regulations
- Resolution #4 — Lancaster County — Nebraska (Preliminary) State Health Plan
- Resolution #18 — Omaha Medical — Policy for Increasing House Officer Membership
- Report of the Board of Directors — Items #1, #9, #12, and #14

Reference Committee #2

- Report of the Executive Director
- Report of the Commission on Association Affairs
- Resolution #5 — Lancaster County — Second Opinion on Surgery Program
- Resolution #12 — Omaha Medical — Nebraska Delegate to Resident Physician Section - AMA
- Resolution #9 — UNMC House Officer Assn. — Reimbursement of Expenses for AMA-RPS Delegates
- Resolution #11 — Omaha Medical — Length of Membership for House Officer Delegates
- Resolution #10 — Omaha Medical — Double Representation of House Officers
- Report of the Board of Directors — Items #4 and #8

Reference Committee #3

- Report of the Editor, Nebraska Medical Journal
- Report of the Commission on Legislation and Legal Affairs
- Resolution #16 — Omaha Medical — Proposed Gasoline Regulation
- Resolution #13 — Omaha Medical — John R. Schenken, M.D.
- Resolution #8 — Hall County — Fee Reimbursement by Blue Cross-Blue Shield
- Report of the Board of Directors — Items #2, #3, and #16

Reference Committee #4

- Report of the Creighton University School of Medicine
- Report of the Commission on Public Affairs
- Resolution #2 — Omaha Medical — Opposition to Universal ID Number
- Resolution #19 — Omaha Medical — Cigarette Sales in Nebraska Hospitals
- Resolution #7 — Hall County — House Parliamentary
- Report of the Board of Directors — Items #6, #10, and #17

Reference Committee #5

- Report of the University of Nebraska College of Medicine
- Report of the Commission on Clinical Medicine
- Resolution #17 — Omaha Medical — Confidentiality of Medical Records
- Resolution #14 — Omaha Medical — Examination of Hospital Records by Third Party Carriers
- Resolution #15 — Omaha Medical — Biochemical Screening of Newborn Infants
- Report of the Board of Directors — Items #5 and #7

Reference Committee #6

- Fifty-Year Practitioners and Life Membership Requests
- Report of the Commission on Medical Education
- Resolution #1 — Omaha Medical — One Class of Physician
- Resolution #6 — Butler County — Participation in PSRO
- Report of the Board of Directors — Items #11 and #13

Dr. Reese said that he thought the Draft Proposal to Perform as Nebraska PSRO from the Colorado Foundation for Medical Care, should be referred to a Reference Committee for their consideration. However the motion to refer this was lost.

There being no further business, the House was recessed until Sunday morning.

SECOND SESSION

The second session of the Fall Meeting of the House of Delegates was held September 24, 1978. The meeting was called to order by the Speaker, Dr. McFadden. Roll call showed 68 delegates present, and the House was declared in session.

Dr. McFadden called for approval of the minutes of the first session, and these were approved as printed.

Reports of the Reference Committees were called for and the following were presented:

Reference Committee #1

Reference Committee #1 considered four reports and three resolutions. The Reference Committee submits the following report and recommendations.

(1) REPORT OF THE DELEGATE TO THE AMA — 1978 ANNUAL MEETING

Recommendation:

Your Reference Committee recommends that the Delegates to the AMA renew past objection to any AMA proposal for National Health Insurance, and we recommend approval of this report.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded. Dr. Cornelius said he felt the NMA should communicate their disapproval to the AMA and moved that the NMA reaffirm its opposition to the AMA introduction of National Health Insurance in the form of a resolution. This amendment was approved and this section of the Reference Committee report was approved as amended.

(2) REPORT OF THE COMMISSION ON GOVERNMENTAL AFFAIRS

Your Reference Committee wishes to commend the Commission on a job well done, and we wish to stress the need for greater involvement of physicians in local Health Service Agencies and the State Health Plan.

We suggest that the NMA develop a method of communication to its membership regarding upcoming business of the Health Service Agencies and the State Health Plan.

Recommendation:

Your Reference Committee recommends approval of this report.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(3) RESOLUTION #4 — LANCASTER COUNTY — NEBRASKA (PRELIMINARY) STATE HEALTH PLAN

Report and comments are covered in the Commission on Governmental Affairs and in the Reference Committee's comments. Your Reference Committee recommends that this resolution not be approved. The resolution read as follows:

WHEREAS, the Nebraska (preliminary) State Health Plan covers in considerable detail nearly all facets of medical practice in Nebraska, and

WHEREAS, the Nebraska (preliminary) State Health Plan contains many statements and recommended courses of action: some reasonable and some unreasonable;

THEREFORE BE IT RESOLVED, that the Nebraska Medical Association

A. Support the concept of local health planning and appropriate coordination of local input into any State Health Plan.

B. Encourage its membership to become familiar with the State Health Plan particularly as it pertains to the members' practice of medicine.

C. Give consideration to assigning to a staff person the responsibility to observe and analyze activities pertinent to the State Health Plan and provide periodic information on the State Health Plan to the Nebraska Medical Association membership via the Nebraska Medical Journal and/or the Nebraska Medical Association News.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(4) RESOLUTION #3 — GREATER OMAHA MEDICAL SOCIETY — UNIFORM IRS REGULATIONS

This resolution reads as follows:

WHEREAS, there is great concern on the part of all our citizens over the deleterious effect of inflation on ourselves, our country, and its wellbeing, and

WHEREAS, medical costs have been inappropriately singled out for special concern in attempting to address the problems of inflation, and

WHEREAS, our Federal income tax structure as presently constituted compounds the adverse effect of inflation by increasing taxation without official authorization, and

WHEREAS, medical expenses are presently treated inconsistently within the structure of the Federal income tax system, and

WHEREAS, the National Commission on the Cost of Medical Care has recommended that consideration be given to treatment of all medical expenses in a consistent manner for purposes of Federal income tax;

THEREFORE BE IT RESOLVED, the Nebraska Medical Association supports the concept that medical expenses should be treated uniformly for Federal income tax purposes, and

BE IT FURTHER RESOLVED, that these expenses should be classified as deductible whether provided by the employer or the employee.

Recommendation:

Your Reference Committee recommends approval of Resolution #3, and that the Delegates to the AMA be instructed to introduce this resolution in the House of Delegates of the AMA.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(5) RESOLUTION #18 — GREATER OMAHA MEDICAL SOCIETY — POLICY FOR INCREASING HOUSE OFFICER MEMBERSHIP

This resolution reads as follows:

WHEREAS, House Officer members of the Nebraska Medical Association have participated actively in the Nebraska Medical Association in the recent past, and

WHEREAS, House Officers represent the future of the Nebraska Medical Association and the American Medical Association, and

WHEREAS, House Officers may represent the Nebraska Medical Association and its members to the

American Medical Association Resident Physician Section, and

WHEREAS, House Officer members of the Nebraska Medical Association who belong to the AMA-RPS are counted towards the number of members for purposes of determining the number of American Medical Association delegates to which the Nebraska Medical Association is entitled, and

WHEREAS, a small number of the over 450 house officers in Nebraska belong to the Nebraska Medical Association and the American Medical Association; therefore be it

RESOLVED, the Nebraska Medical Association shall create an ad hoc committee or assign to appropriate commission this problem and make recommendations to the House of Delegates to increase house officer membership in the Nebraska Medical Association and the American Medical Association. This committee or commission shall report to the House of Delegates at the next annual meeting of the Nebraska Medical Association.

Recommendation:

Your Reference Committee recommends approval of Resolution #18 and commend the House Officers for their comments and helpful suggestions concerning increasing House Officer membership.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(6) REPORT OF THE BOARD OF DIRECTORS — ITEMS 1, 9, 12, and 14

Recommendations:

1. Your Reference Committee recommends approval of Item #1.

2. Your Reference Committee recommends approval of Item #9.

3. Your Reference Committee recommends approval of Item #12, and we wish to encourage our Delegates to meet in an informal manner with the Delegates from Oklahoma and Kansas.

4. Your Reference Committee recommends approval of Item #14.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(7) MINUTES OF THE BOARD OF COUNCILORS

Recommendation:

Your Reference Committee recommends approval of the minutes of the Board of Councilors with the recommendation that the 1973 House of Delegates action regarding Blue Shield be sent to the membership.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #1 AS A WHOLE AS AMENDED. This was approved by the House.

Respectfully submitted,
Russell Gorthey, M.D., Lincoln,
Chairman
William Rumbolz, M.D., Omaha
Dwayne Peetz, M.D., Neligh

Reference Committee #2

Reference Committee #2 considered two reports, five resolutions and two informational items in the Board of Directors report.

(1) REPORT OF THE EXECUTIVE DIRECTOR

Your Reference Committee considered the Executive Director's report and accepted the informational items without change. The statistical breakdown of current membership and practicing physicians in Nebraska was questioned inasmuch as the licensed house officers in the State of Nebraska were not included. Since the licensed house officers in the State of Nebraska number between 400 and 450 and their membership in the NMA could possibly alter our delegate representation to the AMA, it is recommended that their number be included hence forth in the Executive Director's report.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(2) REPORT OF THE COMMISSION ON ASSOCIATION AFFAIRS

Your Reference Committee reviewed and accepted the informational items in this report. Dr. Sievers reported that the Ad-Hoc Committee on Limitations in Reimbursement for Laboratory Services is pending and will be forwarded to the Commission as a whole. The action of the Ad-Hoc Committee on Articles and By-Laws was reviewed and its recommendation relative to Councilor Districts accepted. The Ad-Hoc Committee's recommendation relative to house officer membership was considered in conjunction with Resolution #10 and will be reported later in this report. The Reference Committee reviewed the changes in the assignments of responsibility regarding the Commission on Governmental Affairs and the Commission on Legislation and Legal Affairs and recommends this constitutional change.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(3) ITEM 4, BOARD OF DIRECTORS REPORT RESOLUTION #5 — LANCASTER COUNTY — SECOND OPINION ON SURGERY PROGRAM

Your Reference Committee reviewed Item 4 of the Board of Directors report and Resolution #5 together. Resolution #5 reads as follows:

WHEREAS, the Board of Directors of the Nebraska Medical Association has prepared a statement regarding the "Second Opinion on Surgery Program" by DHEW, and

WHEREAS, this statement is most appropriate with regard to the "Second Opinion on Surgery Program;"

THEREFORE BE IT RESOLVED that the Nebraska Medical Association reaffirm its Board of Directors statement which is as follows:

Several months ago, the Department of HEW decided to launch a second surgical opinion program as part of the Department's overall effort in containing costs.

Two limited demonstration projects (New York and Michigan) costing about a million dollars, are barely under way after the better part of a year's negotiation and planning, but the Health Care Financing Administration of HEW has gone ahead in the face of these obvious warning signs and started a nation-wide program. There is no evidence that this

hastily conceived complex bureaucratic scheme will be cost effective. Indeed, delaying treatment, administrative expenses as well as paying the additional consultant fees, it would seem, would increase the cost of care.

The NMA has always favored surgical consultation when in the patients' best interest and continues to do so, but cannot support a scheme providing poor care in exchange for an envisioned cheaper rate.

The individual surgeon may follow his own conscience about participating as a consultant in private or Federal second opinion programs, but the NMA cannot formally support a federal program established in defiance of strong American Hospital Association, American Medical Association and American College of Surgeons advice against implementing such an activity.

The Board of Directors statement on second opinions was reviewed and due to its negative stance the following changes are recommended:

1. Insert a third paragraph, "The Nebraska Medical Association commends and endorses the principle of cost containment in medicine as evidenced by the formation of a joint cost containment committee with the Nebraska Hospital Association. The NMA will continue to search for effective means of cost containment and will closely examine all proposals brought forth by both the public and private sector."

2. In the fourth paragraph, starting with, "The Nebraska Medical Association has always favored surgical consultation when in the patient's best interest and continues to do so." The Reference Committee recommends deletion of the remainder of the statement.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(4) ITEM 8, REPORT OF BOARD OF DIRECTORS
RESOLUTION #9 — UNIV. OF NEBR. HOUSE OFFICER ASSN. — REIMBURSEMENT OF EXPENSES FOR AMA-RPS DELEGATES
RESOLUTION #12 — GREATER OMAHA MEDICAL SOCIETY — NEBRASKA DELEGATE TO RESIDENT PHYSICIAN SECTION — AMA

Your Reference Committee considered Item 8 of the Board of Directors report and Resolutions #9 and #12 together. These resolutions read as follows:

Resolution #9

WHEREAS, House Officer members of the Nebraska Medical Association who are delegates or their alternates to the American Medical Association Resident Physician Section represent house officers in the state, and

WHEREAS, House Officer delegates and their alternates to the AMA-RPS are members of the Nebraska Medical Association, and

WHEREAS, House Officer delegates to the AMA-RPS represent House Officers and the Nebraska Medical Association to the American Medical Association Resident Physician Section; therefore be it

RESOLVED, the Nebraska Medical Association shall reimburse the expenses of House Officer delegates and their alternates to the American Medical Association Resident Physician Section annual and interim meeting.

Resolution #12

WHEREAS, resident physicians have contributed to the function of the Nebraska Medical Association, and

WHEREAS, the section of the American Medical Association for resident physicians provides a forum for expression of views which will have impact on the practice of medicine in the State of Nebraska; therefore be it

RESOLVED, that the Nebraska Medical Association sponsor,* at least in part, our delegate(s) to the resident physician section of the annual and interim meetings of the American Medical Association, and be it further

RESOLVED, that the Nebraska Medical Association develop appropriate guidelines for attendance, reimbursement, and reports of said delegates.

*NOTE: Possibilities include: a) transportation only; b) fixed stipend; c) fixed per diem; d) some other formula

After considerable discussion as to the activities of the house officers at the national level, your Reference Committee recommends the following:

1. The NMA gives its unqualified support to house officer participation in the resident physician section of the AMA.

2. The NMA subsidize in part the house officer delegates to the resident physician section of the AMA.

3. The house officer delegates to the resident physician section give regular reports regarding their activities to the House of Delegates of the NMA.

4. We recommend that this item be referred to the Commission on Association Affairs to determine the extent of financial support to the house officer delegates by the NMA.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. It was pointed out that financial matters were handled by the Board of Directors. Dr. Fanucchi moved to amend recommendation #4 by stating that following consideration by the Commission on Association Affairs, this be referred to the Board of Directors for determination of the extent of financial support, this to include both the delegate and alternate. This was seconded, and there was discussion as to the number of delegates and alternates from Nebraska. Dr. Fanucchi said this number is based on the number of house officer members from the state, and at the present time there is one delegate and one alternate. This amendment was approved by the House, and this section of the Reference Committee report was approved as amended.

(5) RESOLUTION #11 — GREATER OMAHA MEDICAL SOCIETY — LENGTH OF MEMBERSHIP FOR HOUSE OFFICER DELEGATES

Your Reference Committee considered Resolution #11 and recommends its adoption. The resolution reads as follows:

WHEREAS, House Officer members of the Nebraska Medical Association are by definition members for relatively short periods of time — one to five years, and

WHEREAS, the goal of the Nebraska Medical Association is to encourage the largest number of House Officers possible to join and actively participate in the activities of the Nebraska Medical Association; therefore be it

RESOLVED, the By-Laws of the Nebraska Medical Association be amended by addition to include the following sentences:

Chapter VI — Section 2: A delegate or an alternate representing a component House Officer Society shall have been a member of a component House Officer Society and the Nebraska Medical Association for at least six months preceding his election.

Chapter VI — Section 3: . . . Delegates of a component House Officers Association and their alternates shall be elected for a term of one year.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(6) RESOLUTION #10 — GREATER OMAHA MEDICAL SOCIETY — DOUBLE REPRESENTATION OF HOUSE OFFICERS
SECOND PARAGRAPH OF THE REPORT BY THE AD-HOC COMMITTEE ON ARTICLES AND BY-LAWS OF THE COMMISSION ON ASSOCIATION AFFAIRS

Your Reference Committee reviewed the report of the ad-hoc committee relative to possible dual representation from their component house staff medical association and the component medical society and recognizing that the house officers represent their own component medical society, we recommend adoption of the changes in the By-Laws as presented in Resolution #10, which reads as follows:

WHEREAS, House Officer Associations which hold charters from the Nebraska Medical Association are component societies of the Nebraska Medical Association, and

WHEREAS, House Officer members of the Nebraska Medical Association are represented in the House of Delegates according to the By-Laws of the Nebraska Medical Association under Chapter VI, Section 7, and

WHEREAS, House Officers may also hold membership in a County Medical Society which is also a component society, and

WHEREAS, members of a constituent county society are represented in the House of Delegates according to the By-Laws of the Nebraska Medical Association under Chapter VI, Section 1, and

WHEREAS, the current By-Laws of the Nebraska Medical Association provides for the possibility of double representation of a House Officer member by both House Officer delegate and component county society delegates in the House of Delegates, and

WHEREAS, double representation of House Officers by two component societies is not in the spirit of democracy nor in the best interests of the members of the Nebraska Medical Association, therefore be it

RESOLVED, the By-Laws of the Nebraska Medical Association be amended to include the following sentence.

Chapter VI — Delegates to the House of Delegates — Section 7: . . . House officer members shall not be considered members of a component county medical society for the purpose of determining the number of delegates to which a component county medical society is entitled.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF YOUR REFERENCE COMMITTEE REPORT #2 AS A WHOLE AS AMENDED. This was approved by the House.

Respectfully submitted,
Stanley M. Truhlsen, M.D., Omaha
Chairman
Carl L. Frank, M.D., Scottsbluff
Donald F. Prince, M.D., Minden

Reference Committee #3

Reference Committee #3 considered two reports, three resolutions and three items of the Report of the Board of Directors. Your Reference Committee submits the following report and recommendations.

(1) REPORT OF THE EDITOR OF THE NEBRASKA MEDICAL JOURNAL

Your Reference Committee has reviewed and appreciates the report as received. We wish to commend Dr. Cole for his services in this regard. We would also like to commend him on receiving the Distinguished Service to Medicine Award at the graduating exercises of the University of Nebraska Medical Center.

We recommend acceptance of the report as published.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(2) REPORT OF THE COMMISSION ON LEGISLATION AND LEGAL AFFAIRS

We have reviewed this report in its entirety and wish to offer the following observations regarding testimony received:

a) Items dealing with federal legislation in the future will doubtless be handled by the Commission on Governmental Affairs.

b) The Commission on Legislation and Legal Affairs needs to be in intimate contact with the Nebraska Legislature and to this end the commission chairman is urging increased physician legislator personal contact.

c) An ongoing relationship has been established through personal meetings with the Insurance Commissioner of the State of Nebraska.

d) Recognition is given of the increasingly close relationships that have developed legislatively between the ophthalmologists and the NMA. This is to be commended and we would urge emulation of this relationship with other specialty groups.

e) An editorial change is suggested in the next to the last paragraph of the report to read "James H. Dunlap."

With these suggestions and observations, your committee moves adoption of the Report of the Commission on Legislation and Legal Affairs.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(3) RESOLUTION #16 — GREATER OMAHA MEDICAL SOCIETY — PROPOSED GASOLINE REGULATION

Your committee approved adoption of this resolution which reads as follows:

WHEREAS, the federal government has proposed regulations to be used in the event of a possible gasoline shortage, and

WHEREAS, these regulations limit the usage of two gallons per car per day, and

WHEREAS, there are exemptions to this limit for garbage collectors, ambulance drivers, police and firemen, and

WHEREAS, this limit on physicians would greatly inhibit the practice of medicine particularly in the rural as well as the large metropolitan areas of Nebraska; therefore be it

RESOLVED, that the Nebraska Medical Association request that physicians be added to the list of exemptions and allocation of gas coupons, and further be it

RESOLVED, that this request be submitted to the Nebraska Congressional delegation as well as the American Medical Association.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(4) RESOLUTION #13 — GREATER OMAHA MEDICAL SOCIETY — JOHN R. SCHENKEN, M.D.

Your committee approves adoption of this resolution. We offer our most sincere thanks to Dr. Schenken for his many jobs well done. This resolution reads as follows:

WHEREAS, Doctor John R. Schenken has faithfully served as a Delegate from Omaha to the Nebraska Medical Association from 1957 to 1964, and

WHEREAS, he has served the Nebraska Medical Association as Delegate to the American Medical Association from 1965 through 1978, and

WHEREAS, his leadership has been exemplary over these many years both in regard to maintenance of professional excellence, and also his careful and analytical guidance in socioeconomic problems, and

WHEREAS, he has accomplished all these things with dignity, and at the same time provided the humor and candid remarks we have come to enjoy; therefore be it

RESOLVED, that the Nebraska Medical Association commend him for his many accomplishments as American Medical Association Delegate, and thank him for his long years of devoted service to the physicians of Nebraska.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved unanimously by the House.

(5) RESOLUTION #8 — HALL COUNTY MEDICAL SOCIETY — FEE REIMBURSEMENT BY BLUE CROSS-BLUE SHIELD

Resolution #8 read as follows:

WHEREAS, consumerism and changing laws have changed the original relationship of organized medicine to Blue Cross and Blue Shield from an intimate association to separate and unrelated organizations, and

WHEREAS, there is pending a drastic change in the participation agreements between physicians and the "Blues" requiring acceptance of "usual, customary and reasonable" reimbursements as payment in full as defined by Blue Cross and Blue Shield as a condition of "automatic assignment" (or direct payment to the physician), and

WHEREAS, the physicians fees of the State of Nebraska contribute less than 10% to the cost of medical care to the patients, and

WHEREAS, the physicians of Nebraska are concerned with increased costs of medical care;

THEREFORE BE IT RESOLVED, that the members of the Nebraska Medical Association be advised to consider the Blue Cross and Blue Shield as they would any other third party carrier, and

BE IT FURTHER RESOLVED, that the members of the Nebraska Medical Association make every effort to continue to restrain increasing costs of medical care to their patients.

Your Reference Committee heard considerable discussion concerning this resolution and related items. It is our recommendation that this resolution should be amended as follows:

1) Delete the third and fourth WHEREAS, and substitute the following WHEREAS:

WHEREAS, only one contract between physician and patient is valid and any other contract between physician and third party carrier can tend to subvert and undermine this basic and implied relationship of physician to patient;

2) Delete the last BE IT FURTHER RESOLVED, and substitute the following:

BE IT FURTHER RESOLVED, that the action of the 1973 Nebraska House of Delegates regarding Blue Shield be reaffirmed to read as follows:

1. Blue Shield is a separate corporate entity as is NMA.
2. Blue Shield is an assessment association owned and operated by its subscribers.
3. There are no legal ties between NMA and Blue Shield nor have there ever been. Nothing in the by-laws of one organization can have any effect on the other. The two have had a relationship, sometimes good, sometimes bad, but only a relationship.
4. In addition to 1, 2 and 3 which pertain to corporate relationship there is a relation between Blue Shield and individual physicians applying to participating agreements on the service contracts.

POSITION

1. Determination of quality of care can only be performed by the profession through physician controlled mechanisms based upon criteria and standards locally determined.
2. Need for necessary medical services can be determined only by the physician subject to peer review.
3. Scope of coverage of third parties can only be determined by the third party. This section and 2 above will contain gray areas which should be resolved as stated in 4 and 5 below.
4. All third parties "interfere" to some extent with the physician-patient relationship. The NMA recognizes its Commission on Association Affairs as the proper mechanism for negotiating complaints and maintaining a health liaison with all third parties.
5. The NMA recognizes its Board of Councilors as the proper mechanism for judiciary action.
6. No ties legally bind the NMA to any third party or vice versa.
7. The private health insurance industry, including Blue Shield, is recognized as one phase of a pluralistic system of financing health care.
8. There must be free choice of physician under any system of medical care delivery.

MR. SPEAKER, YOUR COMMITTEE RECOMMENDS ADOPTION OF RESOLUTION #8 AS AMENDED. Following discussion concerning items #1 and #2, it was moved by Dr. Dean to delete #2, which reads, "Blue Shield is an assessment association owned and operated by its subscribers.", and to change all references to "Blue Shield" to "Blue Cross-Blue Shield of Nebraska." This amendment was approved by the House, and following further discussion, this section of the Reference Committee report was approved as amended.

(6) REPORT OF THE BOARD OF DIRECTORS, ITEMS 2, 3 and 16

Your Reference Committee considered Items 2 and 3 as informational items and as such took no action thereon, although Item 3 was considered in connection with the report of the Editor of the NEBRASKA MEDICAL JOURNAL.

Considerable discussion was heard regarding Item 16, concerning the Farmland Industries screening service, which is available in traveling vans manned by three technicians and a registered nurse. To this end, we submit the following resolution entitled, "DIAGNOSTIC SCREENING PROCESSES":

WHEREAS, the practice of quality medical care is predicated upon the doctor-patient relationship with its basic foundation being an adequate history and physical examination, and

WHEREAS, appropriate diagnostic testing can only be directed by the physician after the completion of the history and the physical examination; therefore be it

RESOLVED, the Nebraska Medical Association cannot sanction itinerant "traveling vans" that proffer a variety of medical diagnostic screening tests.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

MR. SPEAKER, I MOVE ADOPTION OF THE REPORT OF REFERENCE COMMITTEE #3 AS A WHOLE AS AMENDED. Dr. Rumbolz moved that Resolution #8 concerning Blue Cross-Blue Shield of Nebraska, as amended, be mailed to the entire membership as early as possible in a separate mailing. This was approved by the House, and the Reference Committee report as a whole as amended was approved by the House.

Respectfully submitted,
James H. Dunlap, M.D., Norfolk,
Chairman
Charles M. Bressman, M.D., Omaha
Gordon D. Francis, M.D., Grand Island

Reference Committee #4

Reference Committee #4 considered three reports and three resolutions. The Reference Committee submits the following report and recommendations.

(1) REPORT OF CREIGHTON UNIVERSITY SCHOOL OF MEDICINE

The report of Creighton University School of Medicine was reviewed and no discussion ensued.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(2) REPORT OF THE COMMISSION ON PUBLIC AFFAIRS

The report of the Commission on Public Affairs was considered.

Particular discussion was focused on "Health Tips." The Commission feels that after reviewing the patient response to a study conducted to these Health Tips, a better marketing effort should be undertaken. The discussion favored the House supporting this effort.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(3) RESOLUTION #2 — GREATER OMAHA MEDICAL SOCIETY — OPPOSITION TO UNIVERSAL ID NUMBER

Much discussion ensued regarding the affect of universal identification numbers and its effect on confidentiality of medical records. This resolution reads as follows:

WHEREAS, the Federal Social Security number was developed by an agency of the Federal government in order to administer its program, and

WHEREAS, the Social Security number has subsequently been widely used by many organizations, institutions, and businesses for purposes other than which it was originally intended;

THEREFORE BE IT RESOLVED, that the Nebraska Medical Association opposes the development and/or utilization of any universal identifier common to personal information, and

BE IT FURTHER RESOLVED, that the Nebraska Medical Association opposes the use of the Social Security number for purposes other than for which it was intended.

Recommendation:

We recommend that Resolution #2 be re-written as follows:

WHEREAS, the Federal Social Security number was developed by an agency of the Federal government in order to administer its program, and

WHEREAS, the Social Security number has subsequently been widely used by many organizations, institutions, and businesses for purposes other than which it was originally intended, and

WHEREAS, the trend to utilization of a universal identification number directly affects the confidentiality of medical information by making it more readily obtainable;

THEREFORE BE IT RESOLVED, that the NMA opposes the development and/or utilization of any universal identifier common to personal information, and

BE IT FURTHER RESOLVED, that the NMA opposes the use of social security number for purposes other than for which it was intended, and that the resolution be communicated to our state and federal legislators.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(4) RESOLUTION #19 — GREATER OMAHA MEDICAL SOCIETY & CREIGHTON HOUSESTAFF ASSOCIATION — CIGARETTE SALES IN NEBRASKA HOSPITALS

This resolution reads as follows:

WHEREAS, the correlation between cigarette smoking and the incidence of chronic lung disease is clear and well-documented, and

WHEREAS, the increasing frequency of cigarette smoking poses a significant threat to the future health of many Nebraskans, and

WHEREAS, the hospitals and other health care facilities of Nebraska should, by their example, demonstrate the highest degree of concern for the medical well-being of Nebraskans, and

WHEREAS, numerous such facilities, by condoning the sale of cigarettes on their premises, have become parties (whether in an active or a passive role) to the promotion of the use of proven pathologic agents by many Nebraskans; be it

RESOLVED, the Nebraska Medical Association strongly discourages the sale of cigarettes on the premises of any hospital or other health care facility within this state, and be it further

RESOLVED, the Nebraska Medical Association urges the immediate discontinuation of the sale of cigarettes on the premises of any hospital or health care facility, and be it further

RESOLVED, the Nebraska Medical Association commends and supports the actions of those hospitals and health care facilities which have prohibited cigarette sales on their premises, and be it further

RESOLVED, that this resolution be communicated to the administrative bodies of all hospitals within Nebraska.

Discussion ensued regarding the distribution of Resolution #10, introduced in May, 1978, regarding Hospital Sale of Cigarettes. There was question whether this was received by hospital staffs.

Recommendation:

We recommend adoption of Resolution #19, with the last RESOLVED to read:

RESOLVED, that this resolution be communicated to the administrative bodies and chief of hospital staffs of all hospitals within Nebraska.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(5) RESOLUTION #7 — HALL COUNTY MEDICAL SOCIETY — HOUSE PARLIAMENTARIAN

Discussion ensued regarding our present Articles and By-Laws and it is felt that the Speaker of the House already has the right to appoint a House Parliamentarian. This resolution reads as follows:

WHEREAS, the deliberations of the House of Delegates of the Nebraska Medical Association are conducted by strict parliamentary procedure in the interests of expediting its business, and

WHEREAS, many delegates are not parliamentarians;

THEREFORE BE IT RESOLVED, that the Constitution and By-Laws Committee provide for the office of Parliamentarian to be filled by appointment by the Speaker of the House with an individual who is qualified by interest and training, and

BE IT FURTHER RESOLVED, that the delegates handbook at each session contain a brief one page summary of parliamentary rules for the delegates guidance.

Recommendation:

We recommend adoption of Resolution #7 with the RESOLVEDS to read:

THEREFORE BE IT RESOLVED, that the office of Parliamentarian of the House be filled by the Speaker of the House with an individual who is qualified by interest and training, and

BE IT FURTHER RESOLVED, that the Delegate's Handbook at each session contain a brief summary of parliamentary rules for the delegates guidance.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(6) REPORT OF THE BOARD OF DIRECTORS, ITEMS 6, 10 and 17

Items #6 and #10 were informational items and no action is necessary.

Item #17, regarding the Western Physician Purchasing Association was discussed at length and no opposition was heard. The purpose of the Western Physician Purchasing Association is to provide a joint purchasing service for professional and office supplies to individual physician members of the constituent State Association. The NMA will not serve any active role in negotiation or purchase transactions. Actual purchase transactions will be between individual physicians and the particular suppliers with whom WPPA has negotiated.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS REPORT OF YOUR REFERENCE COMMITTEE #4 AS A WHOLE. This was approved by the House.

Respectfully submitted,
Kenton Shaffer, M.D., Kearney,
Chairman
Robert Benthack, M.D., Wayne
Edward Malashock, M.D., Omaha

Reference Committee #5

Reference Committee #5 considered four reports and three resolutions. The Reference Committee submits the following report and recommendations.

(1) REPORT OF THE UNIVERSITY OF NEBRASKA MEDICAL CENTER

The report of the University of Nebraska Medical Center was reviewed in the presence of Chancellor Vanselow. We wish to add verbal information that Dr. Allistar Connell has been appointed Dean of the College of Medicine.

We were informed that at this time we do not have the specific name of the rural physician appointed to the Admissions Committee but it is our understanding this appointment has been made or will be made shortly.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(2) REPORT OF THE COMMISSION ON CLINICAL MEDICINE

The report of the Commission on Clinical Medicine was read through. No change, deletions or additions are recommended.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(3) RESOLUTION #17 — GREATER OMAHA MEDICAL SOCIETY — CONFIDENTIALITY OF MEDICAL RECORDS

This resolution reads as follows:

WHEREAS, the Occupational Safety and Health Administration has proposed that access should be granted to an OSHA employee, designated representative, or officials of the agency to the medical record of all employees which would include the employee's personal medical record as well as that employment record relating to occupational exposure, etc., and

WHEREAS, the subject of privacy is of concern to all citizens and has been the subject of a study by the Federal Privacy Protection Study Commission which reported to the President in July, 1977, and contained 162 recommendations for administrative or legislative changes in record-keeping systems maintained by federal, state, and local governments, and the private sector; therefore be it

RESOLVED, that the Nebraska Medical Association opposes the concept of unlimited access to an employee's/patient's personal medical record without the employee's/patient's permission, and be it further

RESOLVED, that the Nebraska Medical Association supports the concepts embodied in the Omnibus Right to Privacy Act, HR 10076, introduced by Representative Richardson Pryor (D-NC), and be it further

RESOLVED, that a resolution to this effect be developed and introduced into the House of Delegates of the American Medical Association at the next meeting.

Considerable discussion led to the recommendation that the second RESOLVED be deleted.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS RESOLUTION AS MODIFIED. This was approved by the House.

(4) RESOLUTION #14 — GREATER OMAHA MEDICAL SOCIETY — EXAMINATION OF HOSPITAL RECORDS BY THIRD PARTY CARRIERS

This resolution reads as follows:

WHEREAS, practically all hospitals require patients to give signed permission for examination of their medical records on admission to the hospital, and

WHEREAS, this is not an informed consent, the record not existing at that time; be it

RESOLVED, permission for the examination of records be given only at or after discharge from hospital, and that such permission should be in writing (not copies) and be current (not over 14 days), and be it further

RESOLVED, that this permission be truly an informed consent, and be it further

RESOLVED, that only that part of the chart be examined which answers written questions for what is needed, and be it further

RESOLVED, that this information be available only to people bound by confidentiality, and be it further

RESOLVED, that this action be sent to the Nebraska Insurance Commissioner and the Nebraska Hospital Association.

After lengthy, interesting, controversial and contradictory presentations by members of the audience, your committee recommends this resolution be referred to an appropriate committee for study and recommendation to the House of Delegates at its next session.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House. Dr. Kelley said that the action of the Board of Councilors concerning Resolution #14 should be included with this resolution when referred. This Board of Councilor action stated, "... only those specifically authorized by the patient should have access to the records."

(5) RESOLUTION #15 — GREATER OMAHA MEDICAL SOCIETY — BIOCHEMICAL SCREENING OF NEWBORN INFANTS

This resolution reads as follows:

WHEREAS, the screening for certain biochemical abnormalities in the newborn infant appears to represent sound medical practice and is generally supported by physicians, and

WHEREAS, the physicians have the primary responsibility for assuring the quality of the medical services provided to their patients, and

WHEREAS, the choice of consulting medical services including clinical pathology laboratory services must remain the prerogative of the individual attending physician; therefore be it

RESOLVED, that the Nebraska Medical Association supports appropriate biochemical screening of newborn infants, and be it further

RESOLVED, that the Nebraska Medical Association opposes a requirement that mandates the laboratory which can perform such biochemical tests and/or the methods by which the tests are performed.

Recommendations:

1. After considerable discussion, your committee recommends addition following the word "infants" in the first RESOLVED, the words "but not by legislation."

2. The committee also recommends adoption of this resolution as modified.

3. Your Reference Committee also wishes to state that we do not interpret the last RESOLVED to preclude use of the tax-supported, state laboratory in those instances where the physician feels this is best for the individual case.

4. We would also like to relay from the audience to the State Department of Health the advice that the State Department of Health should spend their efforts and funds educating physicians and the public rather than attempting to regulate physicians and the public.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. Following discussion, this was approved by the House.

(6) REPORT OF THE BOARD OF DIRECTORS, ITEMS 5 and 7

These two items were reviewed without comment.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(7) MINUTES, BOARD OF COUNCILORS, SEPTEMBER 22, 1978, MEETING

The minutes of the Board of Councilors September meeting were reviewed. No comment or change is recommended.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #5 AS A WHOLE. This was approved by the House.

Respectfully submitted,
C. N. Sorensen, M.D., Scottsbluff,
Chairman
William T. Griffin, M.D., Lincoln
L. J. Chadek, M.D., West Point

Reference Committee #6

Reference Committee #6 considered three reports and two resolutions.

(1) FIFTY-YEAR PRACTITIONER AWARDS AND LIFE MEMBERSHIP REQUESTS

In accordance with a directive from the House of Delegates, each county medical society was contacted by the Executive Office of the NMA to identify those deserving physicians with fifty years or more of active practice, so as to honor them with a fifty-year practitioner award.

The Handbook lists 14 such physicians each of whom has a supporting letter for the award from his county medical society. They are as follows:

Antelope-Pierce County

John H. Calvert, M.D., Pierce

Cass County

Herbert W. Worthman, M.D., Louisville

Dawson County

Victor D. Norall, M.D., Lexington

Dodge County

Dorwin B. Wengert, M.D., Fremont

Gage County

Harry M. Hepperlen, Jr., M.D., Beatrice

Greater Omaha

William R. Hamsa, Sr., M.D., Omaha
Charles W. McLaughlin, Jr., M.D., Omaha
William F. Roth, M.D., Omaha
Ben Slutzky, M.D., Omaha
James P. Tollman, M.D., Tucson, Arizona

Lancaster County

Roland F. Mueller, M.D., Lincoln

Lincoln County

Glen F. Waltemath, M.D., North Platte

South Central

Herman V. Nuss, M.D., Sutton

Southwest Nebraska

Frederick M. Karrer, M.D., McCook

In addition, life membership requests were received for two physicians:

Dodge County

Hamilton H. Morrow, M.D., Fremont

Lancaster County

C. F. Ferciot, M.D., San Luis Rey Downs, Calif.

Recommendation:

1. Fifty-year practitioner awards be granted to the 14 physicians listed above.

2. Life memberships be granted to Doctors Morrow and Ferciot.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(2) REPORT OF THE COMMISSION ON MEDICAL EDUCATION

The report of the Commission was reviewed and was very favorably received.

The Commission's Ad-Hoc Committee on Health Education Report emphasized the need for health education through the state's various school systems. However, there were significant problems involved in the establishment of such a curriculum. It was noted however, there was not comment on the recommendation by the previous committee on health education in schools and colleges pertaining to the development of a research center in health education in Nebraska.

Recommendations:

1. The Commission on Medical Education again consider the establishment of a research center in health education in Nebraska.

2. Acceptance of the report of the Commission on Medical Education as a whole.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(3) RESOLUTION #1 — GREATER OMAHA MEDICAL SOCIETY — ONE CLASS OF PHYSICIAN

Discussion indicated the title of the resolution should be changed to "Teaching Physicians," so as to be more meaningful. The resolution reads as follows:

WHEREAS, the State of Nebraska is fortunate to have two high quality medical schools located within the state, and

WHEREAS, medical education programs have depended and will depend in the future on the close cooperation between fulltime, part-time, and volunteer faculty for the performance of the educational duties required, and

WHEREAS, these educational experiences have and will continue to take place in many settings including university hospitals, Veterans Administration hospitals, community hospitals, and physicians' offices, and

WHEREAS, patients who are admitted to primary teaching hospitals such as a university hospital or a Veterans Administration hospital should receive the same high quality medical care as patients admitted to community hospitals and should expect their physicians to assume medical responsibility for their care, and

WHEREAS, PL 92-603 contained a provision (Section 227) requiring that a method be developed for reimbursing "teaching physicians" in a different fashion from "non-teaching physicians," and

WHEREAS, implementation of Section 227 on the basis of regulations which have been proposed several times over the past five years has the distinct possibility of creating two classes of physicians and therefore, two classes of patients, as well as being unfair to both patients and physicians;

THEREFORE BE IT RESOLVED, that the Nebraska Medical Association supports efforts to repeal Section 227 of PL 92-603, and

BE IT FURTHER RESOLVED, that this position be communicated to our Congressional delegation, the Governor of the State of Nebraska, the American Medical Association, and the Secretary of the Department of Health, Education, and Welfare.

The problems involved with PL 92-602, Section 227, were discussed in considerable length. The expected detrimental affect on our two medical schools from implementation of Section 227 through its HEW proposed regulations were reviewed in depth by officials of the two schools. The high probability of a very serious adverse affect on medical education through the loss of clinical material (patients) was emphasized. In addition, the potential for spread of the regulations to include community hospitals and related staff, because of their necessary involvement in clinical medical education, was identified. These factors were considered to be equal in importance to the resolution's expressed concern regarding the establishment of two classes of physicians and two classes of patients.

Recommendation:

1. Rework the title of the resolution to, "Teaching Physicians."

2. Add the following concern between the third and fourth WHEREAS of the resolution:

WHEREAS, implementation of Section 227 will adversely affect the quality and effectiveness of medical education in the state's two medical schools and their affiliated hospitals, and

MR. SPEAKER, I MOVE THE ADOPTION OF RESOLUTION #1 AS MODIFIED IN THIS SECTION OF OUR REPORT. This was approved by the House.

(4) RESOLUTION #6 — BUTLER COUNTY MEDICAL SOCIETY — PARTICIPATION IN PSRO

This resolution reads as follows:

RESOLVED, that the Nebraska Medical Association continue not to participate in the PSRO program.

The discussion indicated unanimous support for the reaffirmation of the Association's position regarding the

PSRO program. It was therefore recommended the resolution be modified as follows:

RESOLVED, the Nebraska Medical Association reaffirm its position not to participate in the PSRO program.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT AS MODIFIED. This was approved by the House.

(5) REPORT OF THE BOARD OF DIRECTORS, SECTIONS 11 and 13

The discussion of these sections was favorable and resulted in the following recommendations:

1. All plans for an enhanced liaison and cooperative effort between the NMA and the state's two medical schools must be discussed openly.

2. The results of the recently completed physician population study by the Executive Office of the NMA should be published as information for the officials and people of the State of Nebraska.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #6 AS A WHOLE. This was approved by the House.

Respectfully submitted,
F. F. Paustian, M.D., Omaha,
Chairman
T. J. Lemke, M.D., Columbus
Jerry A. Reed, M.D., Lincoln

Dr. Schenken commented to the House concerning PL 92-603, Section 224, regarding laboratory procedures. The motion was made that this information be sent to the NMA membership, and the suggestion was made that it be mailed with the amended Resolution #8. This was approved by the House.

There being no further business, the House was adjourned.

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FRANK COLE, M.D.
Editor

KENNETH NEFF
Business Manager

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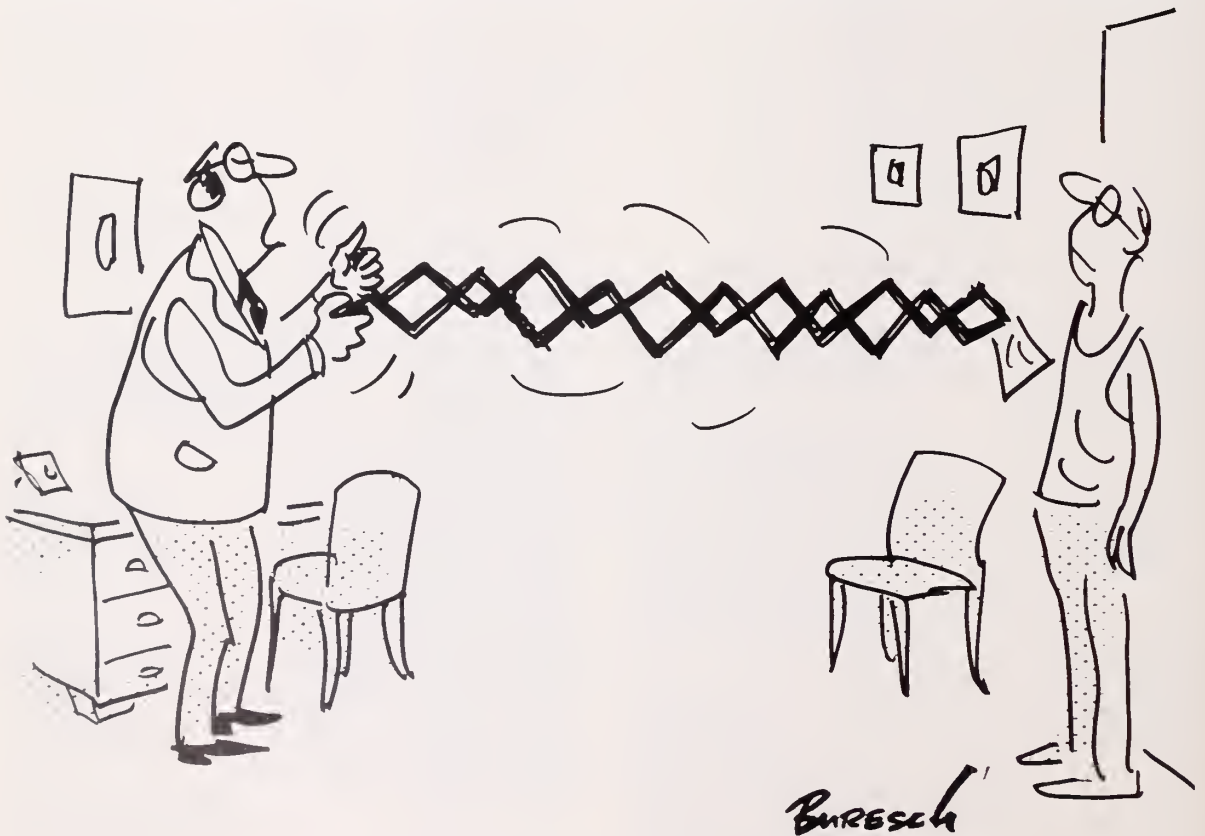
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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and

acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

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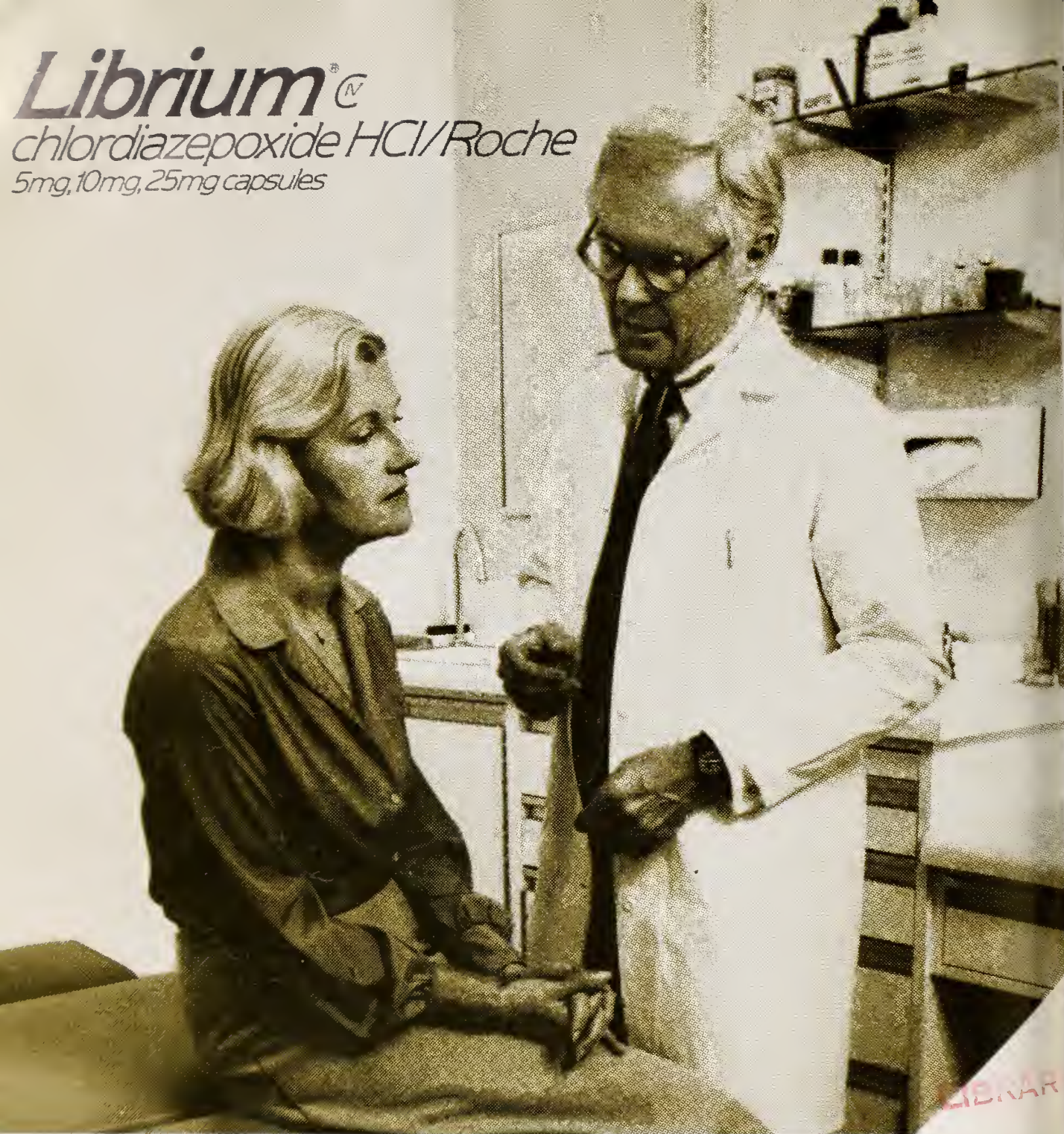
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